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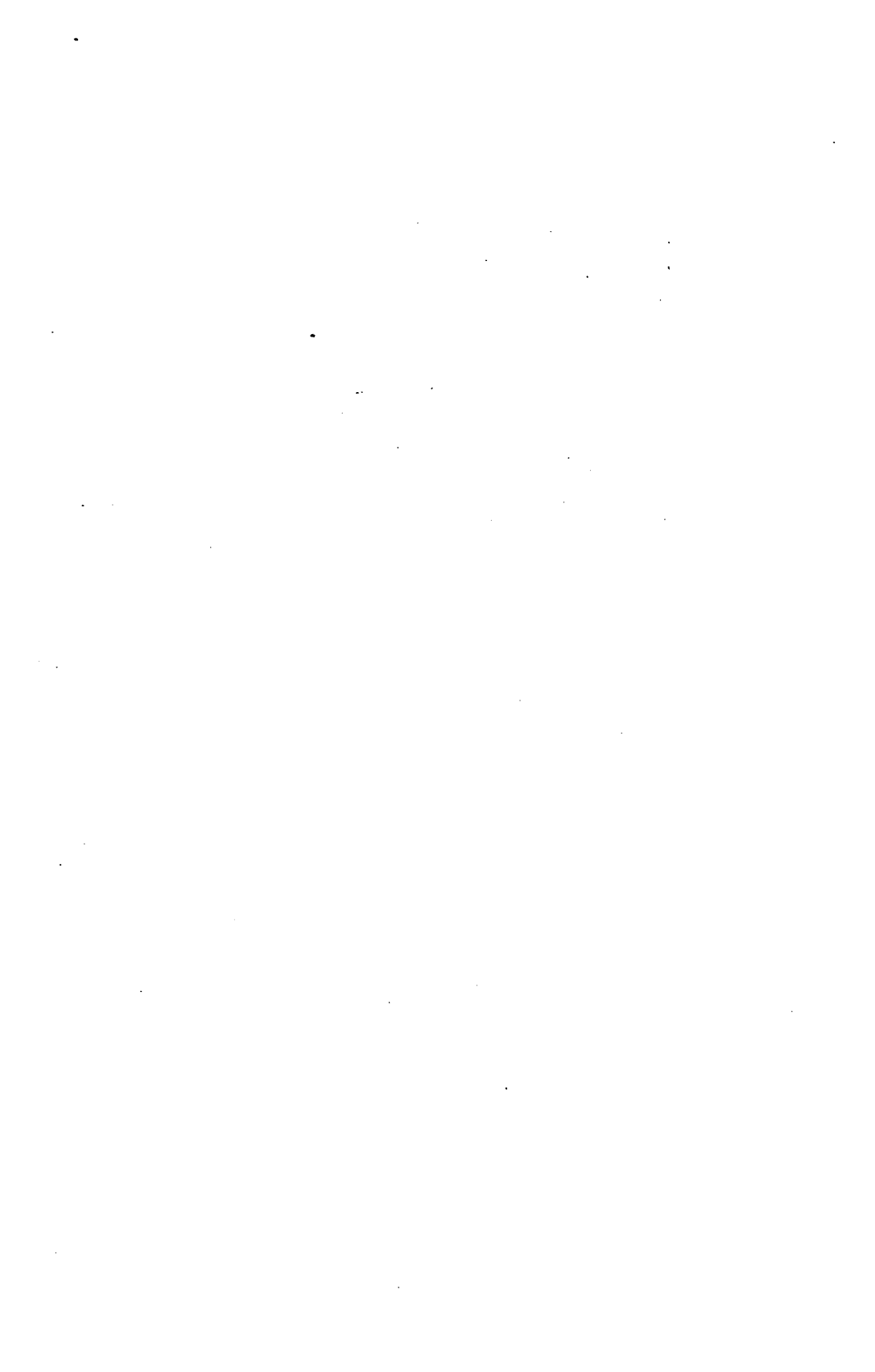
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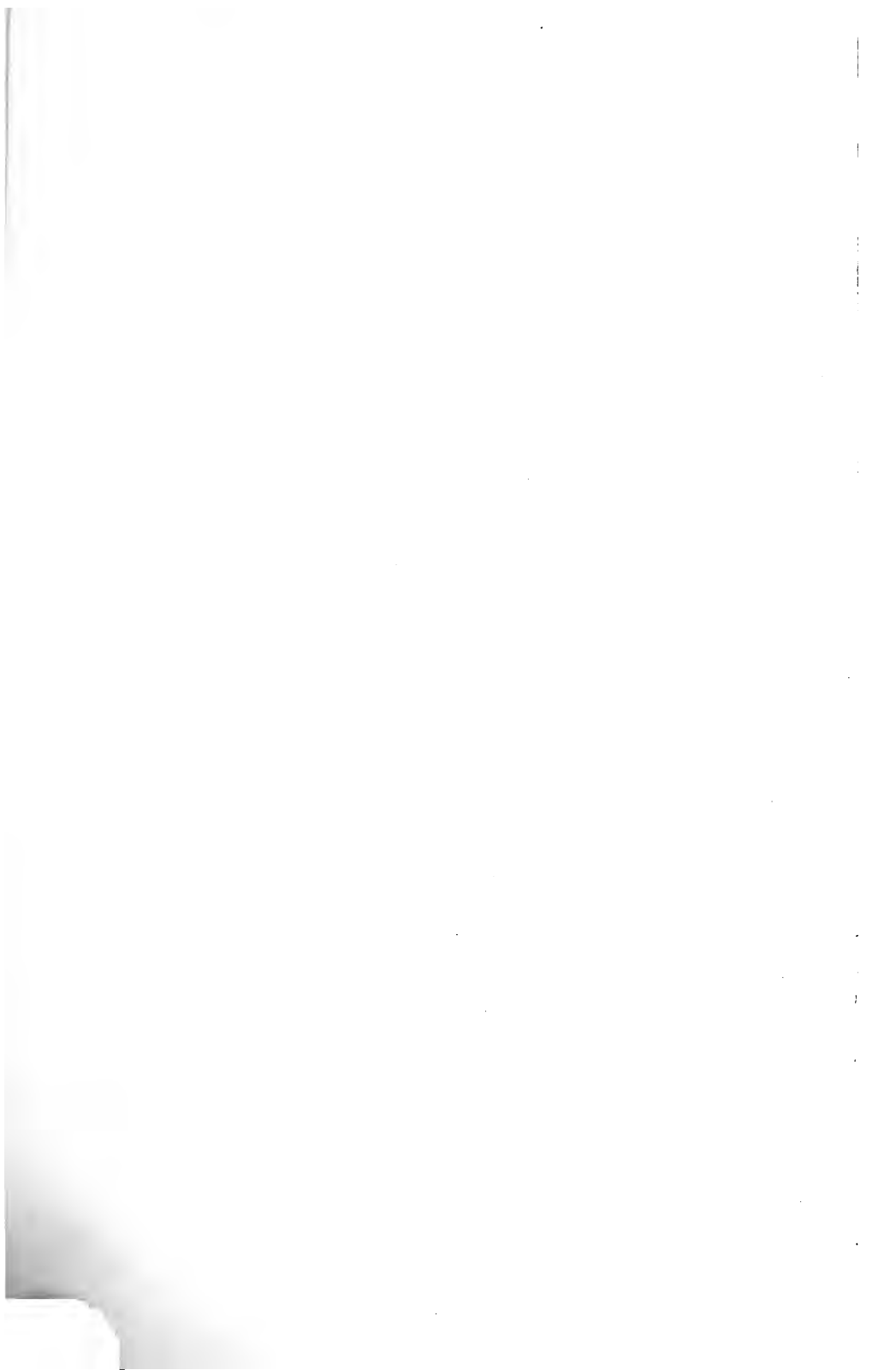
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THE LONDON  
HOMŒOPATHIC  
HOSPITAL REPORTS.

EDITED BY  
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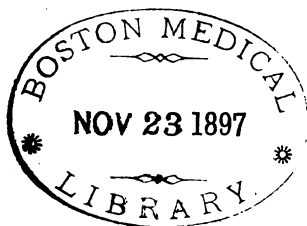
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VOL. III.

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LONDON :  
LONDON HOMŒOPATHIC HOSPITAL.

—  
1893.



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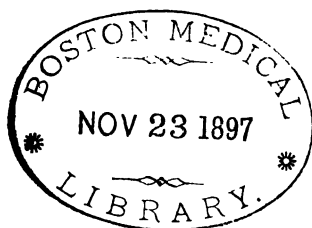
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# HOMŒOPATHIC HOSPITAL REPORTS.

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**ON THE STUDY OF THE SYMPTOMATOLOGY OF THE  
CYCLOPÆDIA OF DRUG PATHOGENESY.**

BY CHAS. HARRISON BLACKLEY, M.D.

ONE of the most important and interesting departments of investigation that can occupy the attention of the physician is the study of the natural history of disease as it occurs in the human organism. It meets him at the very outset of his career, makes continual demands upon his energies, and furnishes an almost inexhaustible field of enquiry during the whole of his professional life. It is, moreover, in proportion to his intimate knowledge of the earliest signs of disease that exists his power of warding it off or of controlling its progress.

Our friends of the opposite school do not always give us full credit for placing a proper estimate upon the value of the facts that may be elicited in an enquiry of this kind, including the phenomena exhibited during life as well as the condition of the organism after death. The state of knowledge in the departments of physiology and pathology in Hahnemann's day justified him, to some extent, for the opinions he then held on these matters. But whatever might have been the state of

the case then, his disciples are fully alive to the value of such an enquiry now. And whatever importance this study has for the adherents of the old school of medicine, it is, for a stronger reason, quite as important to the adherents of the new school. It forms in fact one part of the foundation on which their system rests, and without which no *similia* to the action of drugs could exist.

But for the latter this investigation of the natural history of disease only goes part of the way they must travel. The careful and methodical study of the natural history of drug action on the human body, forms the other portion of the way they must needs go, in order to be fully equipped for the alleviation and cure of disease. And if any system is really and truly deserving of the name *scientific medicine*, it is this method of studying the symptomatology of disease, in combination with the symptomatology of drug action, in accordance with Hahnemann's method of working. It rests upon a foundation of ascertained facts, and the knowledge gained in the latter enquiry is applied to the relief of the maladies shown to exist in the former. But to enable the physician to accomplish this in a satisfactory manner it is important that the history of drug symptoms should be presented to him in as complete and continuous a form as possible.

Like many of my colleagues who practise the homœopathic system, I have often felt the force of these observations, whilst at the same time I have endured the disadvantage of having access to the symptomatology of drugs arranged only in the *schema* form as adopted by Hahnemann. Whilst this method has its uses it must be admitted that it is, in some respects, inconvenient. Although there is still some room for improvement,<sup>1</sup> this inconvenience has been much lessened by

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<sup>1</sup> One of the improvements which is much needed is to extend the provings of some of our drugs so as to elicit all the facts that can be known about their symptomatology. Some very valuable drugs have, on account of their limited provings, not been by any means as much used as they might be. The provings need to be equalised in their extent.

the issue of the "Cyclopædia of Drug Pathogenesis." Previous to the publication of this work we were obliged to make out, as best we could, the natural history of drug action in any particular case. From the homœopathic standpoint this work forms one of the most important contributions to the literature of medicine that has been made during the latter part of this century, and the day will come when both sections of the profession will estimate it at its proper value. All honour to those whose self-denying labours have brought this work to a successful completion.

With all its defects, however, the *schema* plan, as handed down to us from Hahnemann, has some advantages which the more consecutive history of the provings as given in the "Cyclopædia" does not possess; and it occurred to me that if any plan could be devised by which some of the advantages of each could be combined it would be a great gain.

In my student days I adopted the plan of underlining, in some of my text-books, only such portions of the text as were necessary to the full understanding of the author's meaning; and thus some time was saved in reading up the subject.

I had an idea that possibly some use might be made of this method in studying the symptomatology of the Cyclopædia. I was, however, met with the great difficulty at the outset, that there were no parts of the text that could be eliminated in this way, without risk of marring the whole; consequently this idea, in its simple form, had to be given up. It seemed to me, the point to be aimed at was that the symptoms relating to any given organ, or region of the body, in the various provings, should be capable of being read off as easily, or nearly as easily, as they are when placed in a separate paragraph as in Jahr or Allen.

After some failures this was eventually more or less successfully accomplished by the use of colours,<sup>1</sup> for the under-

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<sup>1</sup> In all cases water-colours were used. These should be more or less transparent. Winsor & Newton's, Reeve's, or Geo. Rowney's colours were found to be very reliable, but whichever maker's colours are used they must be the best of their kind.

lining—or to speak more correctly, for the *over-lining*, the *inter-lining*, and the *under-lining*. The colours used were red, blue, bright green, dark green, pink, purple, yellow and grey. By drawing a line with these colours in various positions, with regard to the body of the letterpress, a great variety of idea could be expressed. By using the same colour and by putting this in the same position for every drug in which the same organ was affected, or a similar symptom was manifested, we permanently make that symptom prominent by the use of the colour. Thus the eye could easily single it out from the text without having to wade through other portions in order to find it.

In Allen's "Encyclopædia of Pure Materia Medica" the symptoms are arranged under twenty-five or twenty-six different headings, as the "Mind," the "Head," the "Eyes," &c. As we have eight different colours, and as each of these can be placed in five different positions, it follows that we can have forty different ideas expressed by this method. Of course every practitioner who adopts this plan can select any list of colours he may think most suitable, but when once a selection is made it should be strictly adhered to.

In order to explain my method of working more fully, it will perhaps be well to take some of the symptoms of a well-known drug and shew the effect of this method of working in rendering these symptoms prominent. For this purpose we select the drug Aconite. One of the leading symptoms of this drug is, as everyone knows, disturbance of temperature. In the case of the first prover named "A. B., a healthy peasant girl," only one symptom relating to the disturbance of temperature is given, and this is described as "*general warm sweat*." We pass the names of three other provers before any other disturbance of temperature seems to have been observed. Then we have in the case of Dr. F. H. Arneth "*signs of a chill . . . shivering over back, especially in evening*." In the case of the next prover, Dr. Böhm, after a dose of thirty drops of the tincture of Aconite, we have "*violent rigors, spreading over the back and chest, also recurring very dis-*

*agreeably on least movement during the subsequent great heat . . . . . Sweat after midnight with relief." At 3 p.m. "a repetition of febrile attacks, but chill is weaker ; . . . . perspiration profuse towards morning ; great relief. . . . . In afternoon attack of chill, and heat not lasting long."*

In these and in all subsequent provings, where disturbance of temperature is a marked symptom, this is rendered very prominent by covering the body of the letter with *red* along the whole line of type relating to this symptom. Again, if we take another example from the provings of the same drug—Aconite—we find the same prominence given to any symptom when a different colour is used. As an example of this we find disturbance in the functions of the stomach to be a marked symptom with many of the provers of Aconite. For these symptoms *bright green* was the colour used, and the entire surface of the body of the letter was covered with this colour. For abdominal symptoms *bright green* again was the colour employed, but in this case a narrow line of the colour was drawn through the lower part of the body of the letter. For disordered action of the bowels a dull shade of green was used, and the entire surface of the body of the letter was covered with it.

These examples will give some idea of this method of working and of the effect produced ; but if we give a detailed list of the colours employed, and state the position occupied by each, we shall perhaps give a clearer idea of the whole matter. In doing this we shall follow the arrangement adopted in Allen's "Encyclopædia of Pure Materia Medica":—

*Mind*.—A broad line of a light wash of Indian ink (or lamp-black) drawn above the body of the letter.

*Head*.—A light wash of Indian ink (or lamp black), covering the entire surface of the body of the letter.

*Eyes*.—Blue, covering the body of the letter.

*Ears*.—Blue ; a broad line drawn below the body of the letter.

*Nose*.—Blue ; a thin line through the upper part of the body of the letter.

*Face*.—Pink ; a narrow line drawn through the upper part of the body of the letter.

*Mouth*.—Purple ; a narrow line drawn through the upper part of the body of the letter.

*Throat*.—Purple ; a narrow line drawn through the lower part of the body of the letter.

*Stomach*.—Bright green ; a broad line covering the entire surface of the body of the letter.

*Abdomen*.—Bright green ; a narrow line drawn through the lower part of the body of the letter.

*Stool*.—Dark green ; a broad line covering the body of the letter.

*Urinary organs*.—Yellow ; a broad line covering the body of the letter.

*Sexual organs*.—Yellow ; a narrow line drawn through the upper part of the body of the letter.

*Respiratory apparatus*.—Purple ; a broad line drawn above the body of the letter.

*Chest*.—Purple ; a broad line covering the body of the letter.

*Heart and Pulse*.—Bright red ; a narrow line through the upper part of the body of the letter.

*Neck and Back*.—Pink ; a narrow line through the lower part of the body of the letter.

*Extremities in general*.—Dark green ; a thin line drawn above and below the body of the letter.

*Upper Extremities*.—Dark green ; a broad line drawn above the body of the letter.

*Lower Extremities*.—Dark green ; a broad line drawn below the body of the letter.

*Generalities*.—Without colour.

*Skin*.—Pink ; a broad line drawn above the body of the letter.

*Sleep and Dreams*.—Pink ; a broad line below the body of the letter.

*Fever*.—Bright red ; a broad line covering the body of the letter.



*Conditions.*—Pink ; a thin line drawn through the lower part of the body of the letter.

*Ameliorations.*—Pink ; a thin line drawn above and below the body of the letter.

I have thus given a list of the colours used, and have noted the positions these occupy. At first sight the method appears a little complicated, but it is really not so. It is not, however, nor does it profess to be, a Royal road to the study of symptomatology. This study has to be pursued by laboriously adding line to line and precept to precept, and it is believed that this method will help the student to fix the details in his mind in a more permanent manner than can be done by ordinary reading. One great advantage is that it compels the physician, who adopts the method and does the work for himself, to carefully analyse and differentiate the symptoms produced by each drug ; and it can scarcely happen that in doing this he will not retain in his mind some of the more salient points in the provings, and will more easily remember them. One important point is that the description of the symptom, whatever that may be, is left *in situ* ; the order of its occurrence and its relation to other symptoms are in no way disturbed, and this cannot fail to help the memory to retain some of the facts that are related to each other.

It is not, however, to be supposed that anyone who adopts the method will think it necessary to go through the symptomatology of any one drug and affix all the colours before studying any other drug in the same way. It is highly probable that before he has gone over the symptoms of a few of the leading organs, in any given case, he will have become more or less familiar with the peculiarities of the drug in question, and will only have to refer to its symptomatology occasionally in order to refresh his memory. However this may be, there is this great advantage ; the study can be taken up at any point and can be laid down at any point, according to the individual taste or necessity of the student.

An excellent plan is to begin with the leading, or most

frequent symptom of the drug that is being studied; and after having become thoroughly conversant with this by making it prominent in the way I have described, then to take the symptom next in importance and to treat it in the same way. If this is done *seriatim* for each symptom in the order of their importance, the student cannot fail to have acquired some valuable knowledge of the action of a drug, and he will find that by grouping symptoms together they are more easily remembered than when they are isolated.

I have not, so far, made as much use of this method as I could have wished, but from the short experience I have had of it I believe it will be found to facilitate the acquisition of a knowledge of the range and action of drugs, and will bring into marked prominence the peculiarities in the action of some of them in a way that cannot fail to be satisfactory both to physician and patient.<sup>1</sup>

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<sup>1</sup> It remains now to recapitulate and state the colours used. The red may be bright scarlet or brilliant red. The blue must be bright ultramarine (or French blue). The green is a greenish blue or viridin. It is bright, but not light in colour. The yellow is a yellow by adding a touch of Indian ink to the blue. The black is made by mixing blue and scarlet-lake until it is a very dark green. The gamboge or Indian yellow. The ink or lamp black.

For the thin lines an ordinary pen will do. For the thick lines a fountain pen is best. The Company, of New York, is the best and the least expensive. The pen is filed down to the width

## STUDIES IN THE MATERIA MEDICA.

By D. DYCE BROWN, M.A., M.D.,

*Consulting Physician to the Hospital.*

### TABACUM.

*Nicotiana Tabacum*, Linn.; Natural order, *Solanaceæ*.  
Common name, *Tobacco*. Preparation used, tincture of the leaves.

Tabacum is a most interesting drug, and though so largely used in smoking is scarcely understood in its action, and while a valuable medicine, it is comparatively little used. The proving in Allen's "Encyclopædia" is very full, and derived from a large number (175) of provers. The drug is classed in old-school works as a "narcotico-acrid," and popularly it is thought to be a narcotic. A study of its pathogenesis, however, will clearly show that it is far from being a narcotic. It is a nerve-stimulant in a marked degree, and secondarily, in over-doses, as all nerve-stimulants do, develops the reverse state, one of great nerve-irritation and depression. Its entire action, I may say, falls on the cerebro-spinal nervous system, and the special nerve on which it develops its action most is the pneumo-gastric. Very few people smoke habitually, but in moderation, we have the gentle stimulation of the nerves—after being tired or worried, a feeling of refreshment, improved nerves, which has given rise to the improved appetite and digestion, improved sleep, and sound, healthy, restful sleep. To excess, or when the drug has been taken in overdoses, or in those who show a predisposition to tobacco, preventing smoking in however the pathogenetic symptoms develop.

Such an one presents the condition which I shall briefly sketch, before entering on the detailed proving. He looks pale, or sallow, has a tired, languid appearance, feels disinclined for exertion, mental or physical. He feels weak in mental power, gets depressed, anxious and irritable. He feels physically weak and prostrate. He complains of full or tight frontal headache, is giddy, and liable to neuralgic pain in the teeth and limbs. His eyesight becomes weak, and in extreme cases the optic nerve may take on atrophic degeneration. The stomach and liver become affected with dyspepsia of the nervous type. He loses appetite, feels nausea, or has attacks of vomiting, often in the morning before breakfast, as well as at other times, with faint feeling. There is pain, or sense of heavy uneasiness in the stomach after food, and frequently a "sinking" at the epigastrium between meals. The tongue is red, dry, and tremulous, or coated of a yellow-white colour, and there is a bad taste in the morning. The bowels may get distended and uneasy from rumbling flatulence, with colicky pains; he is constipated, or may have diarrhœa instead, and sense of tenesmus at the anus, and frequent ineffectual desire for stool. He has frequent desire to micturate, the urine being profuse, pale, and watery. The throat becomes relaxed and irritable, causing with similar laryngeal irritation, a dry, worrying, tickling cough, which is evidently mainly neurotic. He feels oppression and constriction in the region of the heart, faintness, sense of dyspnœa and choking, his heart palpitates, especially at night, preventing lying on the left side. His pulse is rapid, feeble, or irregular, and oftentimes becomes slow, but is easily excited to rapidity. He sleeps badly, is long in getting to sleep, wakes frequently with starts and nightmare, and is restless in sleep as well as when lying awake, and wakes unrefreshed. During the day, even, he is restless, and very nervous and depressed. His limbs tremble, and develop nervous twitches, or neurotic pains, or other abnormal sensations. He has pain in the spine, in the nucha, and all down its course, with tenderness in spots, and pains in the lower back after stool. In

extreme cases there is actual fainting, marked convulsions or rigidity of muscles, collapse, cold skin, with cold, clammy perspiration, and death.

With this general sketch, which shows the prominent nerve-depression from over-doses, I now proceed to examine the provings in detail. As in former papers, I adopt the "schema" system, as found in Allen's "Encyclopædia of Pure Materia Medica" (Boericke and Tafel, New York and Philadelphia).

*Mind.* (1) *Emotional*.—Tobacco causes primarily excitement; in one case the conduct of the prover was described as not unlike that of delirium tremens. A sense as of intoxication from alcohol, a merry state of talkativeness and laughter, with singing, is produced. This is followed by the reaction to the opposite state—despondency, low spirits, fear of death, or anxiety, and apprehension of something going to happen, causing gloominess; or a state of marked hypochondria, and nervous restlessness from no other cause, irritability, with irresolution, and feeling of unfitness for work. In one man who, on board ship, slept in a cabin containing large packages of tobacco, he got into a sort of trance, could not move his limbs, everything was confused, and yet he knew where he was, and noticed what occurred in a dreamy way. He managed to crawl up on deck, and got a sailor to souse him with a bucket of water, which roused him up, and then ideas and events which seemed to have passed through his mind when under the influence of the drug, came back in vivid recollection.

(2) *Intellectual*.—The primary effect here also is stimulation, or excitement. Dr. Teste, one of the provers, notes: "Exalted action of the brain, copious flow of ideas; during this sort of intellectual paroxysm, which often continues all night long, leaving me in the morning worn out and sick, I would conceive and elaborate about twenty undertakings, of which probably not one would ever come to light." This was followed by mental depression, confusion of ideas, and lack of words to express them. There is a difficulty of con-

centrating the attention for any length of time on one subject ; weakness of memory. In extreme cases, before death, unconsciousness comes on, with half-open, staring eyes, dilated pupils, and trembling of the limbs, rapid respiration, violent beating of the heart and carotids, thirst, profuse sweat, and cold extremities. *Therapeutics*.—These provings indicate the homœopathic use of tabacum in states of nervous restlessness, with depression of spirits, apprehension, and irritability, with a weakened brain power, or sluggishness of the intellectual faculties. When this state is present by itself, it is useful, but still more when other tabacum symptoms, hereafter to be noticed, co-exist as part of a state of general nerve-prostration.

*Head*.—*Vertigo* is a very frequently noted symptom, sometimes with nausea. *Headache* also is a marked symptom, characterised by a heavy, full sensation, or as if compressed. This may be felt all over the head, but is prominently so in the forehead and temples, and also in the vertex. It is relieved in the open air. Therapeutically, one might prescribe tabacum for such a headache, *per se*, but its presence would be an additional reason for selecting the drug when it is otherwise indicated.

*Eyes*.—The eyes look dull and listless, with a haggard appearance. In one case of an excessive smoker, decided exophthalmos from weakening of the recti muscles is reported. Mr. Jonathan Hutchinson and others give the ophthalmoscopic appearances of cases supposed to be due to tobacco as follows: "The ophthalmoscope demonstrates an atrophic condition of both optic nerves, the inner (apparent) half of each, seen in the reversed image, being quite white and non-vascular ; the outer part being redder, and more vascular than normal." "White or grey atrophy of the optic nerve (in a few cases the colour was bluish-white), commencing at the outer part of the disc, usually with a sharply-defined margin, and with diminishing size of retinal vessels ; in a few cases there were signs of congestion, and in two cases neuritis with indistinct outline of disc. In some cases the centre of disc

was found depressed and atrophied. It is noteworthy that the left eye became first affected, and was more affected than the right in nearly every case. The vision failed suddenly in a few, rapidly in many; in others the progress of the disease was fitful. Some complained of flashes of light, others of fog, but most simply of indistinctness of vision. As the atrophy advanced, the pupils became dilated and insensible to light, and in a few cases divergence of the eyes ensued." "By means of the ophthalmoscope, both optic nerves appear of brilliant white colour, their areas being enlarged, and their outlines clearly defined." "The fundus of each eye seems quite normal, with the exception of the optic discs, which appear too large and irregularly circular, the tissue being quite of tendinous whiteness." In two cases the conjunctivæ were injected. There is frequently uneasiness or aching in the eyeballs, twitching of the lids, and the vision becomes weak, a sense of mist before the eyes, things look indistinct, and he is unable to read small print clearly. The pupils are at first contracted, and in extreme cases become dilated and sluggish to light. *Therapeutics.*—The atrophy of the optic nerve seems only to be the result of very excessive smoking, kept up for a long time, and this shows that an originally functional disorder may in time develop into organic change, when the stimulant is used in excess and for long. When organic changes occur, it would not be of much use to prescribe tabacum, when the atrophy has occurred from other causes, as the tissue cannot be renovated, but in simple gradual failing of sight, with more or less congestion of the disc it is indicated. Tabacum may be very useful in women, or in others who do not smoke; and especially when the general nervous system is in a depressed state, with other tabacum symptoms present.

*Ears.*—The hearing is at first acute, amounting sometimes to hyperæsthesia, with noises in the ears, ringing, humming, or roaring; and in extreme cases the reverse—dulness of hearing. Tabacum would be indicated in a nervous state, when the hearing was painfully acute.

*Nose.*—Nothing of importance here—a slight catarrhal irritation of mucous membrane. The smell is sometimes noted as being too acute, and sometimes the reverse.

*Face.*—In excessive smokers the face looks pale, or sallow, and in veteran workers in tobacco, “a peculiar alteration of the complexion exists; this is not a mere want of colour, or ordinary pallor; it is a dullish grey appearance of the face, partaking both of a chlorotic tinge and of that belonging to certain cachexias. It imparts to the countenance a characteristic look, by which a practised eye can recognise those who have been engaged beyond a certain length of time in the manufacture of tobacco; for it must be remarked that this facial aspect is only to be observed in the case of veteran workers.” The expression is dull and stupid, “indicating lassitude and exhaustion.” In excessive doses, smoking or otherwise, with the nausea to be hereafter spoken of, the face looks deathly pale and covered with cold sweat. In one case a circumscribed redness of the cheeks, especially the left, was so marked that by it his wife could always tell when he had been smoking to excess. As to the occurrence of cancer of the lip in smokers, it is more than probable that this is due, not to the tobacco, but to the irritation of a clay pipe without a mouthpiece. As far as I am aware, it does not occur in those who do not smoke pipes of this kind.

*Mouth.*—There seems to be no doubt, from the provings, that tabacum causes neuralgic toothache. I say neuralgic, as I think there is no evidence that it causes decay of the teeth, though one writer in the *Medical Times* in 1850, maintains that it does. I am inclined to think that, *pace* this writer, decay of the teeth, when present, is due to the gastric disturbance causing acidity. *Apropos* of toothache or neuralgia, chewing a piece of tobacco is a very common remedy for it, and one much believed in among the “masses” in Scotland.

The tabacum tongue is either dry, red and tremulous, or coated with a whitish-yellow coat. This is probably due to gastric disorder. In one case the tongue is noted as



feeling swollen, so that the words run into each other. The mouth may have much tenacious mucus in it, or feel dry, with thirst and a hot feeling in the mouth and throat. As to the flow of saliva, it is popularly supposed that it is much increased, but in the provings this symptom occurred only, or almost so, from taking the tincture in large doses internally, and here probably is a reflex gastric symptom. My own observations lead me to believe that with moderate smoking there is no excess of saliva, and that it is produced by the habit of spitting. Those who smoke pipes even, without spitting, do not find any saliva in excess, but after *excessive* smoking the mouth becomes dry, and the saliva diminishes. It is possible, or probable, that when an over quantity of saliva is formed at first it is due to the local effect of the smoke in the mouth. The taste is "bad," or bitter, or insipid, from over-smoking, and Dr. Teste records that in himself a taste like rancid oil occurred from excess, and a sore spot on the tongue. The latter is probably a mere local effect. It should be stated, however, that in Mr. Jonathan Hutchinson's cases, "constant profuse ptyalism" is noted. Speech may become difficult, as part of the exhaustion of excess.

*Throat.*—There is a catarrhal state of the throat produced, redness of the fauces, œdematous uvula, dryness, or tenacious mucus in the throat, a sense of soreness, or rawness, causing irritating, tickling cough, and a sense of tightness at night, with palpitation. Similar irritation, or dryness, and scraping sensation is noted in the œsophagus, and twice a constant dull pressing uneasiness in the lower part of the œsophagus. In extreme cases of poisoning, swallowing becomes difficult. There is not much therapeutic use to be made of the above except to stop tobacco in anyone who has such a throat.

*Stomach.*—The appetite is primarily increased, but as a reactive effect it is diminished, and with the loss of appetite comes thirst. Eructations of wind, or food, or sour acid occur, hiccough and heartburn. But the most prominent feature is the *nausea* and *vomiting*. It may exist simply as

persistent nausea, or may be followed by severe vomiting of food or sour liquid, and not infrequently so in the morning, before breakfast. The sickness is of a very depressing character, with vertigo, like sea-sickness, and with cold sweat. A marked degree of dyspepsia is produced, with a hypochondriac state, acidity and palpitation. The sensation of "sinking at the stomach" is frequently noticed. There is uneasiness at the stomach, pains of a pressive character, as if he had swallowed something too large; or at times a sharp stitching or cramping pain, or a burning sensation, or at times the reverse, a cold sensation. In several of the provers a sense of "shock" at the epigastrium came on at night, waking them up. One prover described them as like shocks of electricity. *Therapeutics*.—Tabacum will be a valuable medicine in nervous dyspepsia characterised by a general state of nervous depression, nausea in the early morning or at other times, sense of sinking at the epigastrium, want of relish for food, uneasiness in the stomach, or pain of a sharp constrictive nature, coated or red tremulous tongue, relaxed throat and tickling cough, with headaches and depression of spirits, and restless sleep. As a remedy for the depressing nausea and faint feeling characteristic of the drug, tabacum is of great service. I have generally used it in the 3rd centesimal dilution. In sea-sickness it is of decided value.

*Abdomen*.—The liver is affected by tabacum. In one case acute inflammation of it occurred after an excessive bout of smoking. Stitching pains in the liver region are experienced, with a sense of tenderness in the epigastrium on pressure. Pressive, cutting, or cramp-like pains are complained of in the region of the umbilicus. The abdomen becomes distended from flatus, and is sensitive to touch. Occasionally the abdomen is retracted instead of being distended. Rumbling of flatus is felt all through the abdomen, with pressive, contracting, and cramping pains of colic, which are sometimes very severe, and associated with nausea and faintness. With this there may be some diarrhoea, or the reverse. *Therapeutically*, tabacum may be used in abdominal distension,

with rumbling flatus and colic, in a state of depressed nerve-power, with nausea.

*Rectum and Stool.*—Tabacum shows a distinctly irritating action on the rectum. There is burning pain at the anus, with itching, tenesmus, and frequent urging to stool, and pain in the lower back, although the stool is soft and non-diarrhœic. There is sometimes marked constipation ; in other cases diarrhœa of a watery character, with or without griping, the stools often foetid. The diarrhœa is in several cases noted as occurring only in the morning, from 4 a.m. till after breakfast. *Therapeutically*, tabacum may be added to our list of remedies for *morning diarrhœa* which is undeniably of nervous origin, and is not amenable to ordinary diarrhœic medicines, or diet. In constipation, there is no doubt that a gentle dose of tabacum is a valuable aid, especially in nervous subjects. Nearly all smokers have noticed that a smoke is a certain impulse to an evacuation. I have observed also that the time of the smoke regulates the time of the evacuation—that is, morning or evening. In cases where I have given tabacum internally for other reasons, the bowels have acted well, though inclined before to be costive. It is not so much used for this purpose as, perhaps, it should be.

*Urinary Organs.*—There is an irritation of the urethra, burning, itching feeling, noticed by several provers. There is a marked amount of frequent desire to micturate, with, in some cases, a difficulty of retention, or dribbling after micturition. The urine is usually clear and pale, and very free or profuse in quantity. *Therapeutically*, this state points simply to the state of general nerve-depression, such as is found in hysteria, or from nervous disturbances in women, and so would merely be an indication for tabacum, when it is otherwise called for.

*Sexual Organs.*—Nothing here of any importance, excepting as indicating a want of nerve-power.

*Respiratory Organs.*—In a number of provers, there is manifest laryngeal irritation ; a troublesome, dry, tickling cough, or mixed with hiccough, or spasmodic, with burning

feeling in the larynx. This is evidently from continuation downwards of the irritable pharynx, which I have had already to notice, and is clearly partially neurotic, like the *lachesis* cough and irritation. The breathing is at first quickened, and in excessive doses becomes the reverse, slow and stertorous. Besides this, the respiration is frequently noted as being rapid, difficult, and laborious, with sense of dyspnœa, and feeling of suffocation and palpitation. This breathing is clearly neurotic, depending probably on depression of the pneumo-gastric nerve, and on the condition of the heart. There is frequently also, from the same cause, a sense of painful tightness or constriction in the chest, with neuralgic pains of a stitching character in the chest-walls. *Therapeutically*, tabacum will be valuable in this dry, tickling, spasmodic cough, for pharyngo-laryngeal irritation, in which the nerve-element is prominent, like lachesis. The dyspnœa and constriction of the chest will be relieved, along with the heart-symptoms to be presently noted, when tabacum is given for the joint state.

*Heart and Pulse.*—The heart and pulse symptoms are clearly functional and neurotic. They occur most frequently *at night* in bed. There is a sense of constriction or oppression in the præcordial region, with anxiety, and sometimes sharp pain and difficulty of lying on the left side. The action of the heart is at first excited, palpitating and throbbing. The palpitation is a very marked symptom. As a reactive effect it is slow and feeble. The pulse becomes at first rapid and full, and then may become slow, feeble and small. Cases are recorded where it went down to 48 and 34. But the slow pulse is easily quickened by any exertion. It also becomes intermittent. With this state there is a sense of faintness, which may go on to actual fainting. This effect of tabacum, first as an excitant, and then as a depressor of the heart's action, is very characteristic of the drug. The whole condition is that of nervous disturbance, probably acting through the pneumo-gastric, and, as I have already said, the sense of dyspnœa and oppression felt is part of the same condition. *Therapeutically*, tabacum is a very valuable remedy in nervous

heart disorders occurring in non-smokers and women. The case for it is easily seen. There is a general nervous state—one of feeble and easily disturbed nerve-balance—causing palpitation at night, with wakefulness, and sense of oppression or constriction in the region of the heart, with feeling of suffocation or dyspnœa and faintness; the pulse feeble but excitable; and with this nausea, great depression of spirits, and fear of something about to happen, with headache and giddiness. I have often found it in such a case a most important remedy. I usually give it in the 3rd centesimal dilution, frequently at the time of attack, and afterwards three or four times a day.

*Neck and Back.*—Here the symptoms are entirely neurotic. Pain, heaviness, and stiffness in the nucha, tenderness down the spine, chiefly in cervical and lumbar regions, and dull aching pain in the middle of the spine and in small of the back; the latter in one case is noted as being worse after stool; and in the sacrum a beating pain. With this ache in the spine, a bruised feeling over the body, especially in the arms. These symptoms are what one frequently finds in cases of nerve-prostration in women, and an additional indication for tabacum when otherwise suitable.

*Extremities.*—There is a sense of general weakness and feebleness in the limbs, upper and lower, with trembling of them, and unsteady gait. Sense of weariness and prostration in the limbs. In one case, recorded by Dr. Berridge, the following occurred: "a feeling as if the fingers were longer when smoking tobacco in a pipe, after about three inspirations of it; if he continues smoking, he feels as if he had lost the use of his legs from the knees downwards; can smoke a cigar in the open air, but if he smokes half of one indoors, his calves feel as if they did not belong to him, and as if they were dropping away." Sometimes there are spasmodic contractions of the muscles, or stiff rigidity. In another case, "the hands seem paralysed and cold, followed by burning and fuzziness of the tips of the fingers and difficult mobility, with coldness and chilliness of the body." There may be cramps and feeling of formication in the fingers. There are also

pains of various kinds in the upper and lower limbs, cramping, sticking, pressive or tearing.

There is a state of general weakness and prostration, trembling and twitching of the limbs, and great nervous restlessness, requiring continual change of position, with faintness. In extreme cases tetanic convulsions occur in a marked degree. Those who smoke to excess become thin, or even emaciated. *Therapeutically*, tobacco ought to be of decided use in weakness of the upper and lower limbs, either as a part of general nerve-prostration, or as the result of spinal irritation or congestion. It might also be thought of in tetanus, or convulsive attacks, epileptiform, or infantile, from dentition. In the latter especially, remembering its power to cause tooth-ache, it would be indicated. Many cases of "spinal irritation" show to a marked degree the general tabacum symptoms, and I would advise its use in this complaint.

*Sleep*.—The primary effect of tabacum is to promote sleep at night, and after eating. But when taken in any excess the reverse occurs. The prover is long in getting to sleep, starts just as he is dropping off, sleeps restlessly, and wakes frequently. The sleep is disturbed by dreams of an uneasy, nightmare character. *Therapeutically*, tabacum is a most valuable medicine in promoting sleep in a nervous invalid, when this frequent waking and starting up, with nightmare restlessness occurs, or when the patient cannot get to sleep for restlessness and palpitation, with faint feeling, especially, of course, if other tabacum symptoms occur. In such a state I have often found it of much help. This form of sleeplessness is very characteristic of tabacum.

*Fever, Chills*.—When the pathogenetic symptoms are fully developed, the body is cold, or shivering, and the skin covered with cold sweat, while after this stage has passed off, there may be a reaction of decided fever, with marked rise of temperature.

The tabacum symptoms are generally worse at night, and relieved by going into the open air.

Such is the pathogenesis of this interesting drug.

## **SYZYGIUM JAMBOLANUM IN DIABETES.**

BY R. E. DUDGEON, M.D.

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IT was from reading an account of the successful treatment of diabetes by "jumbal," by some native practitioner in India, that I was led, about eight years ago, to try it in some cases of diabetes which happened to be under my care. I had to send to India for the drug, as it was then unknown to the druggists of this country. The medicinal part of the plant is the seeds, which are so hard that they have to be reduced to a fine powder before a tincture can be made from them.

The chief case of diabetes for which I desired the remedy was that of a gentleman who had long resided in India, and who had presented symptoms of diabetes for several years, but had not benefited by any treatment employed. The case was not an ordinary one. I need not enter into a detailed account of his symptoms, suffice it to say he had concomitant signs of atrophy of the liver, and the amount of sugar in the urine was never great, though the quantity of urine passed was very considerable. The appetite was generally very great, and the motions were enormous, but of a very light buff colour and spongy appearance. In this case the *syzygium*, though carefully and repeatedly tried, produced no perceptible effect on the quantity of sugar excreted, which, as I before said, was never very considerable.

The next case was that of an old lady, who first came to me on account of intense pruritus vulvæ, which tormented her day and night. I found that she suffered besides from insatiable thirst and diuresis. I examined the urine and found its specific gravity 1040, and it contained a large

quantity of sugar. Careful dieting and *phosphoric acid* 1x, three times a day, had but little effect on the amount of sugar excreted or the quantity of urine passed, and the itching continued as intense as before. As I had quite lately received a supply of the remedy, I gave her *syzygium*, two drops of the tincture I had myself prepared, in alternation with the *phosphoric acid*, each twice a day. I saw her four weeks later, and ascertained that the pruritus was considerably better, the thirst less, and the quantity of urine passed diminished, though the specific gravity remained at 1037, and it still showed a large amount of sugar. In this way she went on for twelve weeks, the symptoms all considerably relieved, and the specific gravity of the urine fallen to 1032. I then dropped the *phosphoric acid*, and gave her *syzygium* alone, two drops of the tincture three times a day. Under this medicine the irritation, thirst, and abnormal quantity of urine completely disappeared, and though the latter still contains a considerable quantity of sugar, the health of this old lady, now six years after commencing treatment, she being 78 years of age, is very good ; but cataract having developed in both eyes she is not able to get about as much as she would like. The *syzygium* in this case did not eliminate all the sugar from the urine, but under its use the attendant discomforts of diabetes, the thirst, pruritus, and diuresis entirely departed, and she is so well pleased with her condition that she considers herself cured, and is only concerned now about her failing sight.

The best result I have obtained from *syzygium* was in the case of a gentleman, aged 56, who consulted me for what he called "prickly heat." He had intolerable itching all over the upper part of the body and arms, which allowed him no rest at night. The skin when it itched was covered with small papules. He complained besides of intense thirst, and great flow of urine. I found its specific gravity 1036, and it was very saccharine. He had been living for a week past entirely on vegetable food with a view to allay the itching, but it had gone on increasing under the diet. I gave a small phial full of a weak tincture of *syzygium*, and directed him to



take two drops every three hours. He visited me twelve days later, and informed me that he had taken the specific gravity of the urine every day. It was at first 1045, but had now fallen to 1030. He visited me in another twelve days, and I found him quite well. The specific gravity of the urine was 1025, there was no excessive quantity, and it was free from sugar. A year or two afterwards he had an almost precisely similar attack, which yielded equally quickly to *syzygium*. Now, two years after the last attack, he has not had any recurrence of the affection.

I have given *syzygium* in several other cases of diabetes without effect. But this year a lady, whom I had been treating for a serious attack of hæmatemesis, while recovering from the exhaustive effects of her loss of blood, complained of great itching all over, which kept her from sleeping. There was considerable thirst, and the urine was increased in quantity. On examining it I found a notable quantity of sugar, although the specific gravity was not very high—about 1025. A few days of *syzygium* sufficed to eliminate all the sugar from the urine, and to remove entirely the troublesome pruritus. I made no alteration whatever in this patient's diet.

*Syzygium* has recently been introduced into allopathic practice, and several striking cases of its effects in diabetes have been recorded. One writer in the *Berliner Med. Wochensch.* says that the reason why it so often fails is because it is given in insufficiently large doses, and so he begins with 4 grammes increasing the dose to 30 grammes daily. Others have recorded successful results from 5 or 7 grains daily. And at the opposite end of the posological scale is Dr. Swan, of Philadelphia, who wrote me that he had cured himself of diabetes with a high dilution of the drug prepared by himself from a specimen I forwarded to him.

The medicine is now to be had in the ordinary chemists' shops in the form of "perles," each containing  $2\frac{1}{2}$  grains of the drug, so it has evidently gained a footing in old school physic as an anti-diabetic remedy.

## INCIPIENT SIMPLE CATARACT: ITS ETIOLOGY AND TREATMENT.

BY C. KNOX SHAW,

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MANY years ago an enquiring student, even then imbued with the greater possibilities of therapeutics than were acknowledged at his *alma mater*, was questioning a much revered teacher as to the influence of a certain remedy on the course of a disease being then treated on the purely expectant method. This led to a remark which made upon the hearer a very deep and lasting impression; an observation which bears the imprint of an obvious truth, and yet one of which we often need to be reminded when we are endeavouring to demonstrate the curability of disease by drugs. It was to this effect—that we cannot gauge the power of a drug to cut short or cure a disease until we have clearly learnt the course that disease would run uninfluenced by drug action.

Much has been written, especially by the homœopathic school, on the curability of cataract by medicine; but a careful study of the literature of the subject soon convinced me that much of the good effect imputed to drugs was the outcome of a want of knowledge of the course naturally run by cataract, if not due to the possibility of an error of diagnosis having been made.

I have, therefore, been keeping for some years careful notes of all cases of cataract that have come under my observation, with the object of eliciting the following points: the rate of development of cataract; the influence of errors of refraction and accommodation in determining cataract; and

the effect drugs may have, either in causing the absorption of the opacity in the lens, or in arresting its progress.

As an appendix to this paper, I have tabulated 125 cases of incipient simple cataract that have come under my notice during the last thirteen years. They are entirely gathered from my home practice, as it is very difficult to follow up cases sufficiently well at a hospital clinic. These cases may, therefore, be considered to be the basis of my paper. Of course they in no way represent all the cases of cataract that have come under my observation. I have purposely excluded all those cases that were at all advanced when they first came under my care ; and all cases in which, from an ophthalmoscopic examination of the retina and choroid, one might in any way consider the lenticular changes to be secondary to disease in those tissues, or to disease of the iris or ciliary region.

Knowledge of the natural history of cataract must filter through the professional mind to that of the patient, and it is necessary that we as a body should be sure of our facts, as our information materially influences the opinion formed by the laity. It is most distressing to see the depressed mental condition to which a patient may be brought by the knowledge that he or she has cataract ; a distress which a kindly word of encouragement and advice may do much to alleviate. Oculists can do much in this direction ; but it is with the hope that the general practitioner may be in a better position to comfort and help his patients, that his attention is drawn to some of the points in this paper.

#### ANATOMICAL AND HISTOLOGICAL HINTS.

Anatomical points are, alas, soon forgotten, so I venture briefly to recall a few facts connected with the histological anatomy of the lens and its capsule. The lens consists of long prismatic six-sided prisms (held together by a cement) radiating from the anterior and posterior poles, in such a manner as to form a stellate figure. The whole is enclosed in a transparent homo-

geneous membrane—the capsule—from whose inner layers of cubical epithelial cells the lens fibres originate. The nuclear layers of the lens substance are the subject of a process of sclerosis,<sup>1</sup> which commencing in childhood and gradually extending from the centre to the periphery of the lens, causes the nucleus to increase in size with a corresponding diminution of the cortical portion, until in advanced life the whole lens is sclerosed and becomes converted into nucleus. It can easily be conceived that this process of sclerosis, by increasing the rigidity of the lens, interferes with the proper alteration of its shape, so needful for the action of accommodation. On this ground is explained the onset of presbyopia—a diminished power of accommodation. Berry<sup>2</sup> observes that this process of sclerosis is accompanied by a yellowish colour of the lens substance. Clinically this is important, for the more sclerosed the lens the more it reflects light, and thus we often notice in old age that the pupil has lost its pure black colour, and the grey or greyish-green reflex which replaces it may be mistaken for a condition of early cataract.

The lens is supported by the zonule of Zinn, its suspensory ligament, whose fibres arise from the inner portion of the ciliary body and diverging, go partly to the equator of the lens and partly in front and behind the equator to its capsule. This distribution of the fibres of the zonular ligament has an important bearing on the etiology of cataract and will be referred to again. The nutrient material of the lens is obtained from the uvea and ciliary body, and is thought to enter it from the region of the equator.<sup>3</sup>

#### OBJECTIVE AND SUBJECTIVE PHENOMENA.

When entering upon such a discussion as this we should make it quite clear what is meant by incipient simple cataract. In all the tabulated cases I have considered it necessary to

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<sup>1</sup> Fuchs : "Text Book of Ophthalmology," 1892.

<sup>2</sup> George A. Berry : "Diseases of the Eye," 1893.

<sup>3</sup> Fuchs : *Loc. supra cit.*

have seen certain objective signs with the ophthalmoscope before making a diagnosis of incipient cataract. By transmitted light small fine striæ or dots were observed in the periphery of the lens; sometimes the changes were in the nucleus, but in these instances peripheral changes generally co-existed. The pupil was not dilated in every case where the nuclear appeared to be the only change, or I expect I should have invariably found equatorial as well as central opacity. No case has been admitted to the table that did not pass the ophthalmoscopic test.

When examining the lens I have on several occasions observed a condition I have termed in my note book "fibrillation of the lens." By transmitted light the lens does not appear to be of a perfectly homogeneous transparent character, but reveals the fact that it consists of bundles of fibres. My impression is that this is a condition that may not be inaptly called the pre-cataractous stage of cataract, though I have not been able to follow up a sufficient number of cases to prove it. We shall see later on that there is in early cataract a separation of the fibres of the lens and that a fluid fills up the spaces so formed. This fluid would not necessarily render the lens opaque, but would be visible owing to the unequal refracting power of the two substances. This condition seems quite compatible with normal acuity of vision, and is quite distinct from the Y-shaped figure so often seen in adults by means of oblique illumination of the pupil, and which is merely a normal physiological arrangement — the stellate figure of the lens. These sectors are often very clearly marked in advanced pathological changes in the lens.

This condition also seems to be different from that described by De Wecker<sup>1</sup> as a common senile change and which he terms lenticular arcus senilis, but which might also very well be classed among the pre-cataractous symptoms. He has noticed a circle of opacities at the periphery of the lens, which he considers due to the movement of shrinkage in

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<sup>1</sup> De Wecker : " Ocular Therapeutics," 1879.

the nucleus. "This becoming sclerosed draws towards it the peri-nuclear layers, and this attraction is propagated in succession to the layers nearest the capsule." This separation of the fibres, to be followed in time by opacity, takes place where the capsule receives the imprint of the substance of the zonula. This condition may apparently remain unaltered for years, or nutritive changes may be set up in the lens and true cataract develop. If I understand De Wecker aright, he does not call this condition cataractous, but I certainly should feel inclined to consider it as a sure forerunner of cataract, even if we might not almost consider the process to have begun.

In addition to the purely objective signs observed by the surgeon, patients generally mention certain subjective symptoms, the chief being multiple or distorted vision, fixed muscæ, a slowly developing short-sight, and that whereas they formerly needed reading glasses they now are able to discard them. There may be some photophobia or even complaint of phosphenes; asthenopia and pain on using the eyes are not unfrequently observed. Brailey<sup>1</sup> summarises the symptoms he has observed to accompany incipient cataract as follows:—

"(1) A conjunctivitis, which is often attended with much lachrymation and photophobia, and which is usually rendered worse by astringents.

"(2) Aching pain on use of the eyes, especially on prolonged near work.

"(3) A slight degree of undue redness of the optic disc, other than would be accounted for by changes in the media.

"(4) Changes in the refraction, spasm of accommodation being sometimes present, or more often, slight myopia or myopic astigmatism being developed."

All these symptoms might well be caused by accommodative or refractive changes, and attention to them is sometimes followed by an actual improvement in vision.

It ought to be made very clear by a careful examination

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<sup>1</sup> W. A. Brailey: "Some points in the development of Cataract," *Trans. Ophthalm. Soc.*, vol. xi.

of the fundus of the eye, that none of the symptoms are due to retinal or choroidal disease, as visual improvement might be set down to an improvement in the condition of the lens, whereas it was really due to an abatement of the more deeply-seated lesion.

The onset of myopia—acquired myopia as it is called—is due to the increased density of the lens heightening its refractive power. Reference to the table will show that myopia was found in 40 per cent. of the cases. In many instances the myopia clearly preceded the development of the cataract, but in others the state of the refraction could only be attributed to the altered density of the lens. The occurrence of myopia in these cases of incipient cataract, accounts for what is popularly called “second sight,” and which is often looked upon by the patient as something to be proud of. The altered refractive index of the eye brings the near, or reading point, which has been gradually receding as years went on, closer to the eye again, and so patients are able, either to weaken their reading glasses, or in some instances, to do away with them altogether.

I have noted over and over again that the diminution of visual acuity bears apparently no definite relation to the changes visible in the lens to the ophthalmoscope. In certain cases, where the changes appear to be very slight, the vision is poor in comparison. One would naturally suspect that there were other changes in the fundus of the eye, but I have failed to establish this point; nor am I able to advance a satisfactory reason to account for the disparity.

In some of the recorded cases a concave lens would restore the acuity of vision to normal, such a state remaining unchanged for years. I have, therefore, been disposed to look upon this too as the pre-cataractous stage of cataract. When we come to consider the etiology and pathology of cataract, it will be seen that this condition warrants careful attention, as my experience would make me believe that it is at this stage that most can be done to arrest the progress of cataract.

Personally I lean to Becker's views as to

#### THE PATHOLOGY OF INCIPIENT CATARACT,

and considering them in the light of Schoen's<sup>1</sup> later investigations, as to the etiology of the cataractous process, they make a very feasible and workable hypothesis.

It may, I think, be taken as clearly demonstrated that there is a normal physiological sclerosis and consequent shrinkage of the nucleus of the lens going on from early life; but what determines the disturbance of balance, so as to convert a normal physiological process into a distinct pathological change, is as hard to discover as is the cause of the tissue involution of the body in old age. At some period, however, in the life history of the lens, and yet not in every lens, the process advances too rapidly for the cortex to adapt itself to the diminished volume of the nucleus, and so causes a separation of the fibres. The spaces, or vacuoles, thus formed, are filled with fluid. The fluid having a different refractive index to the lens substance, will cause the separation to be seen with the ophthalmoscope, but producing only an apparent opacity, as during this stage the vision may not be materially impaired. Later on the fibres themselves become cloudy, and later still they are thought to break down completely, undergoing a kind of fatty degeneration, forming what Fuchs calls a pultaceous mass. Next there takes place "a gradual resorption of the pultaceous lens masses: and in this way lenticular opacities may clear up again; not, to be sure, in the proper sense of the word, by the opaque lens fibres becoming once more transparent, but by the disappearance of the opaque parts."

Whilst most observers are agreed as to the pathological anatomy of the lens affected with early cataract, yet the greatest difference of opinion exists when we come to discuss the cause that leads to the deviation from the physiological to the pathological.

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W. Schoen: "The cause of Senile Cataract," *Archiv. Ophthalm.*, vol. xviii., 1889.



## THE ETIOLOGY OF THE CATARACTOUS PROCESS.

At one time the degeneration was considered to be the outcome of senile marasmus, a view held by both Wolfe<sup>1</sup> and Juler.<sup>2</sup> Berry<sup>3</sup> considers the main cause to be a too rapid or irregular abstraction of fluids, which is favoured by some interference with the supply, or some abnormality in the constitution of the nutritive fluids. Dr. Collins,<sup>4</sup> after an examination of the composition of the human lens in cataract, came to the following conclusion: that "cataractous lenses contain relatively less water and more solids and ash than non-cataractous lenses, and that the dehydration associated with opacification is in no sense a change dependent upon age, and has no parallel in the ordinary changes which age brings with it in the clear lens."

Fuchs,<sup>5</sup> too, considers that, though frequently occurring among old people, the changes are not to be considered a physiological attribute of old age, as grey hair.

Deutschmann thought there was generally a pre-existing albuminuria; Michel, an atheromatous degeneration of the carotids, but these theories have certainly not been confirmed by other observers.

Soelberg Wells<sup>6</sup> considered the change to be due to impaired nutrition, induced by some morbid alteration in the vitreous. Mooren states that the condition is never a primary but a secondary phenomenon, in which view he is supported by Buffum,<sup>7</sup> who looks to a morbid condition of the vitreous or aqueous as the primary cause. Compton Burnett considers the excessive use of sugar, salt or calcareous water, as produc-

<sup>1</sup> Wolfe. "Diseases and Injuries of the Eye," 1882.

<sup>2</sup> Juler: "Ophthalmic Science and Practice," 1884.

<sup>3</sup> *Loc. supra cit.*

<sup>4</sup> W. J. Collins: 'The Composition of the Human Lens, in Health and in Cataract, and its Bearing upon Operations for the Latter.' *Ophthal. Review*, vol. viii., 1889.

<sup>5</sup> *Loc. supra cit.*

Soelberg Wells: "A Treatise on the Diseases of the Eye," 1873.

Buffum: "Diseases of the Eye," 1884.

tive of cataract. Beebe<sup>1</sup> says that if we examine cataract patients thoroughly "we will find them more or less diseased." Edward Blake, who sees septic auto-intoxication in most diseases, believes careful investigation will reveal, in patients suffering from cataract, pus depôts in the alveolar processes of the maxillæ, in the endometrium of the cervix uteri, or other parts.

Two drugs at least have been known to produce cataract, secale and naphthaline. Ignatz Meyer and Tepljaschin<sup>2</sup> have both recorded cases of secale cataract, and an interesting feature in both reports is the fact that the cataract was preceded by fits. Tepljaschin noted an epidemic of raphania in 1879-80, of a convulsive type. In 1882 cataract patients, between 30 and 40 years of age, began to appear, who had suffered from convulsions. Tepljaschin thought the secale caused the cataract by the disturbance in the nutrition of the lens, produced by the convulsions, or by the spasm of the blood vessels. Cataract has been known to follow other forms of convulsions, viz.: during teething and in epilepsy.

Stein induced cataract in young guinea-pigs by placing the animals in the resonator-box of a tuning fork. The cataract produced by naphthaline will be seen from a study of the drug in the "Cyclopædia of Drug Pathogenesis,"<sup>3</sup> to be secondary to a retinitis, accompanied with vitreous opacity, and in some cases, detachment of the retina. Kolinsky's<sup>4</sup> experiments clearly show that the lenticular changes were secondary to pathological changes in the ciliary region, ciliary processes and retina.

Both Berry and De Wecker consider that heredity plays an undoubted and important part in the etiology of cataract,

<sup>1</sup> E. W. Beebe : "Incipient Cataract," *Journ. of Ophth., Laryng. and Otol.*, vol. ii.

<sup>2</sup> A. Tepljaschin : "Cataract resulting from Chronic Poisoning with Secale Cornutum." Congress of Russian Physicians, 1888.

<sup>3</sup> Vol. iv., p. 653.

<sup>4</sup> Kolinsky : "Contribution to the Knowledge of the Action of Naphthaline on the Eye, and on the so-called Cataract," *Graef's Archiv. f. Ophthal.*, vol. xxxv.

and according to Berry, the hereditary tendency is to descent by the male rather than by the female line.

Within more recent years, a few men have been working at the subject, with a view of studying the influence of accommodation on the development of cataract; and as these investigations support the conclusions I had drawn from purely clinical experience, I have reserved their consideration until the last.

Helmholtz clearly demonstrated the mechanism of accommodation to depend upon the elasticity of the lens, which is influenced by the tension of the fibres of the zonule of Zinn; the effect of the tension being thrown principally upon the equator of the lens. Magnus,<sup>1</sup> writing in *Von Graefe's Archives*, states that senile cataract begins, in the large majority of cases—nearly 93 per cent.—by the appearance of cortical opacities close to the equator of the lens, and immediately beneath the capsule.

Schoen,<sup>2</sup> having made an examination of 5,642 eyes, of which 4,030 were examined ophthalmoscopically and the vision tested, the rest being externally diseased, comes to the conclusion that—

(1) The process heretofore distinguished as senile cataract begins always as equatorial cataract, with fine white dots and streaks.

(2) Nuclear sclerosis never appears without equatorial cataract, but equatorial cataract distinctly exists without nuclear sclerosis.

(3) More than half (60 per cent.) of the patients with cataract have still normal acuteness of vision, wherefore changes in the centre of the lens may be excluded.

(4) Three-fourths of the total number of cataractous eyes are hyperopic or astigmatic.

(5) The macroscopic dots and stripes correspond to the insertion of the anterior and middle zonular fibres.

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<sup>1</sup> H. Magnus : "Experimental Study of the Nutrition of the Lens and the Formation of Cataract, *Graefe's Archiv. f. Ophthalm.*, vol. xxxvi., 1890.

<sup>2</sup> *Loc. supra cit.*

(6) The microscopical changes likewise are arranged around the base of these fibres.

These investigations tend to establish two facts, one that the site of the early lenticular opacity is at the equator of the lens, which Helmholtz has shown bears the brunt of the accommodative strain ; and another, the great frequency with which hyperopia or hyperopic astigmatism occurs in these cases.

Schoen<sup>1</sup> further considers that the dragging on the zonular fibres witnessed in over-exertion of the accommodation, exercises upon the capsular epithelium an irritation which excites the latter into subdivision of cells, but is at first confined to the neighbourhood of the foot of the fibres. "We find localised inflammatory proliferation of the capsular epithelium directly behind the equator, corresponding to the insertion of the middle zonular fibres, and a similar proliferation corresponding to the insertion of the anterior zonular fibres, and at this point the lens has begun to participate in the process in the form of incipient cataract."

When we remember that we have a natural physiological process—sclerosis and shrinkage of the nucleus—going on in the lens, favouring the separation of the cells at its equator ; that the changes are most marked in advanced life, when the presbyopic period coming into existence, causes considerable accommodative strain, and that this strain is materially increased if the presbyopia be added to any pre-existing error of refraction, we may, I think, consider with reasonable probability, that the accommodation plays a prominent part in the development of incipient cataract.

Magnus<sup>2</sup> points out, too, that the accommodation regulates the nutritional current, and that when this is disturbed the stream is diminished, as it enters the lens through the region of the equator ; the consequent denutrition assisting in the shrinkage of the lens fibres.

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<sup>1</sup> W. Schoen : "Over-exertion of the Accommodation and its Results," *Archives of Ophthal.*, vol. xvii.

<sup>2</sup> H. Magnus : *Deut. Medic. Wochenschr.*, 1888.

The 125 cases I have collected show normal vision in either one or both eyes in 38 instances, or 30 per cent. of the whole. One hundred and fourteen, or 91 per cent., had errors of refraction; 51 per cent. having hyperopia or hyperopic astigmatism, and 40 per cent. myopia or myopic astigmatism. In three cases the refraction was not noted, and in eight it was emmetropic, but these eleven had the accommodative strain of the presbyopic period. It is interesting to note that only 20 per cent. of the cases were males, so that a very large preponderance of the patients, 80 per cent., were women.

Risley,<sup>1</sup> writing on the etiology of incipient cataract, lays great stress on the part played by errors of refraction in the development of the cataractous condition. He analysed 80 cases, and found 70 per cent. had demonstrable errors of refraction. In 30 per cent. it was not possible to determine with any certainty the state of the refraction owing to the condition of the media. Hyperopic astigmatism was noted in forty-one, and myopic astigmatism in seventeen cases.

In estimating the influence of the presbyopic period on the cataractous stage, we learn from the hundred and twenty-five cases that I have tabulated, that in only one was lenticular opacity noted before 40 years of age, a patient in whom hyperopic astigmatism existed. Nine, or 7.2 per cent., of the cases occurred between 40 and 50; thirty, or 24 per cent. occurred between 50 and 60; fifty-one, or 40.8 per cent. occurred between 60 and 70; twenty-nine, or 23.2 per cent., occurred between 70 and 80; and five, or 4 per cent. of the cases were noted in patients over 80 years of age.

#### RATE OF DEVELOPMENT.

Having studied the position of simple cataract from its histological, pathological and etiological standpoint, there remains another question that needs our thoughtful attention before we are able to express any opinion as to the influence

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<sup>1</sup> Risley: "Incipient Cataract, its Etiology, Treatment, and Prognosis," *Ophth. Rev.*, vol. x., 1891.

of drug action in removing the cataractous changes altogether or in arresting their progress, viz., the rate of development of simple cataract. There is a very general belief, not supported by facts, that cataract must progress surely, but steadily, to inevitable blindness. This fallacy, as I feel inclined to call it, has a firm hold, not only of the profession, but also of the public, notwithstanding the teaching of some of our most experienced ophthalmologists.

Out of the appended table there are only thirty-nine cases that can be used to throw any light on this question of the rate of development, as many have not returned for re-examination. I am inclined, however, to think, that had vision materially diminished in some of them, I should have seen them again, especially as most of the patients were referred to me in the first instance by my colleagues under whose medical care they were.

Of these thirty-nine, five, or nearly 13 per cent., were found on re-examination to have definitely and distinctly improved vision; the shortest interval between the first and last examination being seven months, and the longest three years. In none of these cases do I find a record of any medicine given, but, as is usual with me, suitable spectacles were ordered, free use of the eyes allowed, and any existing conjunctivitis remedied.

Fifteen cases, or 38 per cent., remained almost, if not entirely, stationary; the shortest time between the examinations being six months, and the longest eleven years. One case was examined after seven years interval, and another after six years, the rest averaging a year and a-half.

Fifteen others, 38 per cent., could only be described as slightly worse, distant vision lessening by one line of Snellen's test-type; and the vision remaining useful for reading in the great majority of cases. Excluding one that was examined a month after the first visit, the average duration of observation of these cases was decidedly longer than in the stationary ones; in one the examination was made six years after the first note; in three 4 years; in three 3 years; in five 2 years; and in two 1 year.

In only four cases, or about 10 per cent. of the total number, could I say that vision was decidedly worse ; one after nineteen years ; one after twelve years ; one after four years ; and one after three years. But in none of the four cases had the cataract arrived at a state of maturity suitable for extraction.

Brailey, in a paper already quoted, found that 7 per cent. of his total number of private patients had some degree of cataract. He watched 31 cases, and, as a result of the study of them, he comes to the conclusion that "the majority of immature cataracts undergo little change for the worse as time advances." Of the 31 noted cases, 14 remained absolutely stationary for periods varying between three months and eight years. Four of them even got slightly better, six became but slightly worse, seven became decidedly worse.

These figures speak for themselves and clearly show that the rate of development of cataract is slow, and may even come to a standstill, as Meyer<sup>1</sup> says. Norton,<sup>2</sup> however, thinks that simple senile cataract, as a rule, follows a progressively increasing course from incipency to full maturity.

Many observers, as Fuchs, Meyer, Berry, speak of the variableness of the rate of development, and mention cases of cataract that have even ripened in a few days, but these rapid cases are secondary to some serious lesion in the eye or accompanied by some grave constitutional derangement, as diabetes, and are therefore not the class of cases now under consideration. It is well to realise clearly the probabilities of the rate of progress of cataract, for patients are constantly asking, "How long will it be before I go blind, and need an operation?" The wise man, who has a due regard for the sure fulfilment of his prophetic instincts, will honestly say he does not know, for I have heard many a bitter thing said of those who rashly say that the patient will be blind in two years—the limit usually given. There is a point that may serve as a

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<sup>1</sup> E. Meyer : "A Practical Treatise on Diseases of the Eye," 1887.

<sup>2</sup> A. B. Norton : "Ophthalmic Diseases and Therapeutics," 1892.

slight guide in estimating the probable rate of progress, and that is, that the broader the striæ the more rapid the progress; fine hair-like striæ and dots do not appear to progress as rapidly as the other variety.

Seabrook,<sup>1</sup> writing on the natural course of cataract concludes:—(1) that it is the rule for senile cataracts to show improvement at some time in their course; (2) that it is exceptional for pathological changes to remain absolutely stationary, permanently to improve or to disappear.

Angell<sup>2</sup> records the case of a patient, aged 80, who consulted him, who had been told by a leading oculist 20 years previously that he had cataract, and who was able to use his eyes comfortably till quite recently, when a nuclear opacity commenced. He mentions another case of a woman, aged 63, who first saw him in 1888, she had cataract and slight myopia. She required + 4D for reading, and could see with tolerable ease. She received no treatment, and at each visit subsequently, in Nov., 1888, March, July and October, 1889, her acuteness of vision varied, being sometimes better and sometimes worse.

A sufficient number of cases have now been recorded to clearly establish the fact that cataract may very rarely undergo spontaneous absorption, but these, as a rule, are lenses in which the cataract has reached the stage of maturity.

#### TREATMENT.

Whilst conceding a due amount of respect to the wisdom and weight of "authority," we are naturally disposed, in these progressive days, to consider whether its dicta are to be received with an unquestioning adherence. Scarcely anything, I think, has added more to the miseries of the incipient cataractous stage than the almost universal acceptance of the

<sup>1</sup> Seabrook: "The Natural Course of Cataract," *Medical Record*, 1891.

<sup>2</sup> H. C. Angell: "The Variable Progress of Senile Cataract," *Journal of Ophthalm., Laryng. and Otol.*, vol. ii.



opinion laid down in our text books, that nothing can be done for those in whom incipient cataract is diagnosed, but to wait patiently for an inevitable blindness. Years ago, I had come to the conclusion that a more hopeful and optimistic view might be taken, and it is now evident, from papers read before the various ophthalmic societies, and from others to be found scattered throughout the various medical journals, that an opinion is being formed that judicious treatment may delay the progress of the incipient stage into the more mature cataract. The following are the usual text book opinions: "Every sort of medicinal treatment is ineffectual against cataract" (Fuchs). "No medicinal treatment known which will promote a natural cure" (Berry). "I know of no means of checking the growth of a senile cataract" (De Wecker). "In no case can the opacity of the lens be made to recede by the use of therapeutic means" (Juler). Such statements as these have led, not only to no effort being made to relieve patients therapeutically, but to the formation of an opinion that it is hopeless to expect any sort of treatment to be of any avail.

Various methods of treatment have been proposed.

Galvanism has been employed by Colbourne,<sup>1</sup> who reported decided benefit in six cases out of nine in which it was used. Beebe employs it habitually, but he does not think it has any advantage over other local irritants. A. B. Norton finds no benefit from it. Dr. A. J. Erwin reported to the American Medical Association (Section of Ophthalmology), 1892, a series of cases in which vision had remained unchanged or notably improved under the use of galvanism, and the application of tincture of iodine to the lids.

Kalish<sup>2</sup> has recorded cases of immature, uncomplicated cataract, in which reading power has been regained and incipient cataract entirely absorbed by instilling into the eye

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<sup>1</sup> J. E. Colbourne: "The Galvanic Current in the Treatment of Cataract," *Journal of American Medical Association*, 1887.

<sup>2</sup> R. Kalish: "Absorption of Immature Cataract by Manipulation, with Instillations," *Medical Record*, 1890.

two drops of a solution of equal parts of glycerine and a one per cent. solution of boric acid in rose water. Three fingers are then placed on the closed eyelid, and a stroking movement, with slight pressure, is made from the nasal to the temporal side of the eye. This must be repeated from twenty to thirty times a minute for ten minutes, and then a fresh instillation and fresh movements are made. Continued daily for three or four months, this treatment has, according to Kalish, been productive of much benefit.

Risley,<sup>1</sup> after a wide experience, is convinced that "in many cases, the apparently progressing opacity of the lens can be arrested, in others the rapidity of its increase greatly retarded" by as complete a rest as possible from all near work, the use of smoked glasses, and the local employment of some mild washes to the conjunctiva; any existing error of refraction being carefully corrected, and the correcting glasses ordered to be worn constantly.

George Critchett<sup>2</sup> strongly urged that we should not assume the hopeless do-nothing position, but should correct any error of refraction, use neutral tinted glasses, and, allaying as far as possible, the natural anxiety of the patient, let them use their eyes moderately.

Swanzy<sup>3</sup> takes very much the same view, advising his patients to make all the use of sight they can.

Brailey, however, considers the improvement noted in his cases to be due to the *diminished* use of the eyes he enjoins on his patients.

Amongst oculists of the homœopathic school, Norton, King, Buffum and Beebe write confidently as to the power of drugs to check the further progress of cataract, whilst Angell<sup>4</sup> holds an opposite view.

<sup>1</sup> S. D. Risley: "Incipient Cataract, its Etiology, Treatment and Prognosis," *Ophthalmic Review*, vol. x., 1891.

<sup>2</sup> G. Critchett: "Practical Remarks on Cataract," *Ophth. Rev.*, vol. i., 1882.

<sup>3</sup> Swanzy: "Handbook of Diseases of the Eye," 1888.

<sup>4</sup> H. C. Angell: "Diseases of the Eye," 1891.

As the actual local symptoms provided by a cataract patient are often of a very unstable quantity, all observers are agreed that in selecting a remedy one "must be guided, not only by the condition of the lens or the eye, but also by the general symptoms presented by the patient." Beebe expresses the opinion that drugs administered upon "experimental methods based upon pathology are unable to meet the peculiarities of these cases."

A large series of carefully observed cases under medical treatment form the subject of an able paper by Dr. A. B. Norton,<sup>1</sup> which merits careful consideration. The paper is based upon 295 cases of incipient cataract from his own and his late brother's practice. All secondary, zonular and almost mature cataracts are excluded. One hundred of these had more or less treatment for periods of three months or over. He noted improved vision in 13 per cent., that vision remained stationary in 42 per cent., that it became slightly less in 26 per cent., and decidedly less in 19 per cent., thus giving 55 per cent. of successes, 26 per cent. of favourable results, and 19 per cent. of failures.

The only other statistics bearing on these points I have been able to find are Brailey's, and, comparing these two with my own we get the following results :—

| Vision:—  |     |     | Improved. | Remained Stationary. | Slightly less. | Decidedly less. |
|-----------|-----|-----|-----------|----------------------|----------------|-----------------|
| Norton    | ... | ... | 13 %      | 42 %                 | 26 %           | 19 %            |
| Brailey   | ... | ... | 13 %      | 45 %                 | 19 %           | 22 %            |
| Knox Shaw | ... | ... | 13 %      | 38 %                 | 38 %           | 10 %            |

A comparison of these figures is interesting, for, as far as I can judge, the treatment of the cases has been conducted

<sup>1</sup> A. B. Norton : "The Homœopathic Treatment of Incipient Senile Cataract, with Tabulated Results of One Hundred Cases," *North American Journal of Homœopathy*, 1892.

on somewhat different lines. Norton's cases have had careful and prolonged medical treatment; Brailey's cases were enjoined diminished use of the eyes; and mine were allowed free use of the eyes short of fatigue. Under the first heading there is no difference at all in any of the cases; under the heading "remained stationary" there is but little difference, Brailey having the largest proportion of unchanged cases. There is greater divergence when we come to consider those in which the vision was "slightly," and those in which it was "decidedly less." Some of this may be due to some variation in what each observer would call "slightly less," but it is clear from Brailey's paper that he had some more advanced cases than I included, as in four of the cases included under the head "decidedly less" extraction was performed, whereas in none of my "decidedly less" cases was the cataract sufficiently advanced to be extracted.

For Norton's 100 cases 22 remedies were principally used. *Causticum* was given in 64 cases, its principal indications being, "feeling as if there were sand in the eyes, sensation of pressure in the eyes, heaviness of the lids, burning, itching of the eyes, with a desire to keep them closed, photophobia, flashes of light before the eyes, winking and twitching of the lids."

*Calcareo phosph.* was considered the next most useful medicine, and was prescribed because of the symptoms—"headaches, especially of the right side, pain around the right eye, aching in the right eye, tired feeling in the right eye, eyes feel stiff and weak, dizziness, rheumatic pains." In addition, Norton used *sepia*, *phosphorus*, *iodoform* and *naphthaline*.

Dr. King,<sup>1</sup> writing on the medical treatment of incipient cataract, admits that "his prescriptions are entirely empirical and based largely on general considerations and past experience." He certainly records a striking case of an alcoholic,

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<sup>1</sup> W. R. King: "The Medicinal Treatment of Incipient Cataract," *Journ. Ophthalm. Laryng. and Otol.*, 1892.

with left hemiplegia, who also had cataract, and for whom he prescribed *iodoform* 3x, on account of its similarity to certain gastric symptoms from which the patient was suffering. Within three months vision had markedly improved and he could read the newspaper, this improvement being maintained until his death two years later. In other cases improvement was obtained with *iodoform* 3x, after other remedies had failed to make an impression. Dr. King also gives cases relieved by *sulphur* 30.

Dr. Lamb<sup>1</sup> records a case which improved markedly in eleven months whilst taking *sulphur*, *calcareo carbonica*, *euphrasia*, *pulsatilla* and *silica* all in the 30th dilution.

If we review the remedies that have been found most helpful in cataract cases we must notice *first*, that in only two of those employed has cataract ever been known to have been produced by the drug, *naphthaline* and *secale*. I have shown earlier in the paper why we should not look to *naphthaline* to help us in simple cataract. It is only after serious changes have been observed in the retina and ciliary region that the cataract develops as a secondary change, a condition we very often see in corresponding diseases of the eye.

*Secale* has not many eye symptoms, and appears to have been used but little. In addition to those already mentioned who have observed cataract to develop as a consequence of chronic ergotism, the "Cyclopædia," quotes Meier, of Kronstadt; the main eye symptoms gathered from the pathogenesis are :—

- Dilatation of pupils ;
- Blurring and dimness of vision ;
- Sensations before the eyes as if it lightened ;
- Sparks flitting before the eyes ;
- Light painful to the eyes ;
- Redness of optic papillæ.

All these symptoms can be much better ascribed to dis-

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<sup>1</sup> "A Case of Senile Cataract treated Homœopathically," *North American Journal of Homœopathy*, 1892.

turbance of the accommodation, with retinal hyperæsthesia, than to any change in the lens itself. Then it should be noted that the cataractous changes noted in *secale* do not immediately follow its use, but are subsequent to its prolonged action on the ciliary muscle.

This leads me to notice, *secondly*, that if we study the pathogenesis of the other drugs considered most useful in cataract, we shall find that the symptoms for which the drug is prescribed are mainly accommodative. Those of *causticum* and *calcareæ phosph.* I have given above.

Take *sulphur* and *sepia*, for example, their indications are clearly for their action on the conjunctiva, lids and accommodation; *phosphorus* and *conium* are evidently only useful for their action on the retina and accommodative apparatus, and so on through the list of remedies recommended to cure cataract. I fancy that the idea of senility as an etiological factor in cataract has led to the choice of *silica* as a remedy, for its action upon the globe itself is very slight.

Thus it appears to me that the very remedies themselves that experience has found to be helpful in cases of simple cataract tend to support the accommodative theory of its development.

If this is the case we should be encouraged to persevere on these lines, and if this paper has done nothing else, the investigation necessary for its preparation has strengthened me in a desire, not so much to set out to cure cataract, but by careful correction of any error of refraction, and medical treatment directed to the relief of the accommodative symptoms, to endeavour to arrest the progress of the change, and to place the patient in a better condition for fulfilling his allotted daily task.

An important point arises when patients first come under observation—Should we tell them that they have cataract?

As a rule I do not, but generally acquaint the medical attendant or some intimate friend or relative. This is necessary, for otherwise when the patient discovers the fact, you are open to the charge that you have failed to diagnose so im-

portant a condition. The patients' distress, on knowing their condition, militates against the successful treatment of the ocular condition, and so it is best for them not to know at first.

I would sum up the treatment that should be employed as follows :—

(1) Not to inform the patient of the condition of the lens.

(2) To correct carefully any error of refraction, and if some of the impaired vision depends upon that error to order the spectacles to be used constantly, and if there is any sensitiveness to light to have them slightly tinted.

(3) To prescribe internally and locally for any conjunctivitis or obvious accommodative symptoms.

(4) To allow the patient full use of the eyes short of fatigue.

In conclusion, I would ask attention to the following propositions :—

(1) That simple cataract is not *per se* a senile change.

(2) That the prime factor in its development is eye strain, due to over-exertion of the accommodation.

(3) That its rate of development is slow, and that in many cases it may never reach maturity.

(4) That mechanical means, such as spectacles, to remove the primary, and carefully selected medical treatment to remove the secondary effects of the eye strain, will delay the progress of simple cataract, and in some cases will for a time cause an improvement in the condition of the lens.

| No. | Date.       | Age. | Sex. | Vision.                                 | Refraction. | Last seen.  | Vision.                                                      | Treatment.                   | Remarks.                                                      |
|-----|-------------|------|------|-----------------------------------------|-------------|-------------|--------------------------------------------------------------|------------------------------|---------------------------------------------------------------|
| 1   | Feb., 1881  | 58   | M.   | { R. E. J. 6 }<br>L. E. J. 2            | H.          | July, 1892  | { R. E. $\frac{1}{8}$ & J. 2 }<br>L. E. $\frac{1}{8}$ & J. 1 | Spectacles                   |                                                               |
| 2   | July, 1882  | 69   | F.   | B. E. J. 6                              |             | May, 1883   | B. E. J. 12                                                  |                              |                                                               |
| 3   | Oct., 1882  | 65   | F.   | B. E. $\frac{1}{8}$                     | M.          | July, 1894  | B. E. $\frac{1}{8}$                                          | Spectacles                   | 2 years previous to exam. was said to have cataract by Mr. P. |
| 4   | July, 1883  | 57   | F.   | B. E. $\frac{1}{8}$                     | H.          | .....       | .....                                                        | .....                        |                                                               |
| 5   | Feb., 1884  | 69   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          | Dec., 1893  | B. E. $\frac{1}{8}$                                          | Cauticum and Spectacles      |                                                               |
| 6   | Mar., 1884  | 50   | M.   | L. E. $\frac{1}{8}$                     | M.          |             |                                                              |                              |                                                               |
| 7   | April, 1884 | 60   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          | Sept., 1890 | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$                      |                              |                                                               |
| 8   | May, 1884   | 44   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          | Dec., 1884  | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$                      | Spectacles                   |                                                               |
| 9   | June, 1884  | 68   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |             |                                                              |                              |                                                               |
| 10  | July, 1884  | 80   | F.   | B. E. $\frac{1}{8}$                     | H.          |             |                                                              |                              |                                                               |
| 11  | July, 1884  | 54   | F.   | B. E. $\frac{1}{8}$                     | M.          |             |                                                              |                              |                                                               |
| 12  | Aug., 1884  | 77   | F.   | B. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |             |                                                              |                              |                                                               |
| 13  | Nov., 1884  | 58   | F.   | B. E. $\frac{1}{8}$                     |             | June, 1885  | B. E. V. $\frac{1}{8}$                                       |                              |                                                               |
| 14  | Feb., 1885  | 52   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M. A.       | Jan., 1888  | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$                      | Cannabis Sat. and Spectacles |                                                               |
| 15  | Mar., 1885  | 60   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          |             |                                                              |                              |                                                               |
| 16  | July, 1885  | 60   | F.   | B. E. $\frac{1}{8}$                     | H.          |             |                                                              |                              |                                                               |
| 17  | July, 1885  | 60   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |             |                                                              |                              |                                                               |
| 18  | Aug., 1885  | 72   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |             |                                                              |                              |                                                               |
| 19  | June, 1886  | 50   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          | Sept., 1887 | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$                      | Spectacles                   |                                                               |
| 20  | July, 1886  | 62   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          | Mar., 1892  | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$                      | Spectacles                   |                                                               |
| 21  | Sept., 1886 | 84   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          | Oct., 1887  | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$                      | Spectacles                   |                                                               |
| 22  | Sept., 1886 | 57   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          |             |                                                              |                              |                                                               |
| 23  | Sept., 1886 | 75   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |             |                                                              |                              |                                                               |
| 24  | Oct., 1886  | 46   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |             |                                                              |                              |                                                               |
| 25  | Nov., 1886  | 43   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |             |                                                              |                              |                                                               |
| 26  | Nov., 1886  | 56   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H. A.       |             |                                                              |                              |                                                               |
| 27  | Feb., 1887  | 57   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          | .....       | .....                                                        | .....                        | R. E. Mature Cataract.                                        |
| 28  | April, 1887 | 70   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |             |                                                              | .....                        |                                                               |
| 29  | May, 1887   | 55   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          | Sept., 1890 | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$                      | Spectacles                   |                                                               |
| 30  | June, 1887  | 63   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          | .....       | .....                                                        | .....                        | L. E. Mature Cataract.                                        |
| 31  | Jan., 1888  | 70   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          | .....       | .....                                                        | .....                        |                                                               |
| 32  | Feb., 1888  | 71   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          | .....       | .....                                                        | .....                        | Was said to have Cataract 19 years ago R. E. by Mr. C.        |
| 33  | April, 1888 | 61   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ |             |             |                                                              |                              |                                                               |
| 34  | April, 1888 | 60   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M. A.       |             |                                                              |                              |                                                               |
| 35  | April, 1888 | 63   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |             |                                                              |                              |                                                               |



| No. | Date.       | Age. | Sex. | Vision.             | Refraction. | Last seen. | Vision.                                 | Treatment.    | Remarks.                                                   |
|-----|-------------|------|------|---------------------|-------------|------------|-----------------------------------------|---------------|------------------------------------------------------------|
| 36  | May, 1888   | 76   | F.   | R. E. $\frac{1}{2}$ | H. A.       | .....      | .....                                   | .....         | L. E. almost Mature Cataract.                              |
| 37  | May, 1888   | 60   | F.   | R. E. $\frac{1}{2}$ | H. A.       | .....      | .....                                   | .....         |                                                            |
| 38  | May, 1888   | 59   | F.   | R. E. $\frac{1}{2}$ | M.          | .....      | .....                                   | Spectacles    |                                                            |
| 39  | May, 1888   | 72   | M.   | R. E. $\frac{1}{2}$ | Em.         | .....      | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | .....         |                                                            |
| 40  | June, 1888  | 47   | F.   | R. E. $\frac{1}{2}$ | M.          | .....      | .....                                   | .....         | R. E. Mature Cat., L. E. Im-                               |
| 41  | Sept., 1888 | 79   | F.   | R. E. $\frac{1}{2}$ | M.          | .....      | .....                                   | .....         | mature.                                                    |
| 42  | Nov., 1888  | 55   | F.   | R. E. $\frac{1}{2}$ | H. A.       | .....      | .....                                   | .....         | L. E. Mature Cataract.                                     |
| 43  | Jan., 1889  | 66   | F.   | R. E. $\frac{1}{2}$ | M.          | .....      | .....                                   | .....         |                                                            |
| 44  | Jan., 1889  | 63   | F.   | R. E. $\frac{1}{2}$ | M.          | .....      | .....                                   | .....         |                                                            |
| 45  | Feb., 1889  | 70   | M.   | R. E. $\frac{1}{2}$ | H.          | .....      | .....                                   | .....         |                                                            |
| 46  | Feb., 1889  | 57   | F.   | R. E. $\frac{1}{2}$ | H.          | .....      | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles    |                                                            |
| 47  | Mch., 1889  | 69   | F.   | R. E. $\frac{1}{2}$ | M.          | .....      | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles    |                                                            |
| 48  | Mch., 1889  | 70   | F.   | R. E. $\frac{1}{2}$ | M.          | .....      | .....                                   | .....         |                                                            |
| 49  | April, 1889 | 76   | F.   | R. E. $\frac{1}{2}$ | H.          | .....      | .....                                   | .....         |                                                            |
| 50  | April, 1889 | 60   | M.   | R. E. $\frac{1}{2}$ | M.          | .....      | .....                                   | .....         |                                                            |
| 51  | June, 1889  | 60   | F.   | R. E. $\frac{1}{2}$ | Em.         | .....      | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Lycop. Sepia. | L. E. Advanced Cataract.                                   |
| 52  | July, 1889  | 64   | F.   | R. E. $\frac{1}{2}$ | H. A.       | .....      | .....                                   | Spectacles    |                                                            |
| 53  | July, 1889  | 60   | F.   | R. E. $\frac{1}{2}$ | H.          | .....      | .....                                   | .....         |                                                            |
| 54  | Aug., 1889  | 64   | F.   | R. E. $\frac{1}{2}$ | H. A.       | .....      | .....                                   | .....         | L. E. Mature Cataract.                                     |
| 55  | Sept., 1889 | 58   | F.   | R. E. $\frac{1}{2}$ | Em.         | .....      | .....                                   | .....         |                                                            |
| 56  | Oct., 1889  | 67   | F.   | R. E. $\frac{1}{2}$ | Em.         | .....      | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | .....         |                                                            |
| 57  | Oct., 1889  | 55   | F.   | R. E. $\frac{1}{2}$ | M. A.       | .....      | .....                                   | .....         |                                                            |
| 58  | Oct., 1889  | 52   | F.   | R. E. $\frac{1}{2}$ | H. A.       | .....      | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles    | R. E. probably not affected.                               |
| 59  | Nov., 1889  | 70   | F.   | R. E. $\frac{1}{2}$ | H.          | .....      | .....                                   | .....         |                                                            |
| 60  | Nov., 1889  | 80   | F.   | R. E. $\frac{1}{2}$ | H.          | .....      | .....                                   | .....         |                                                            |
| 61  | Nov., 1889  | 64   | F.   | R. E. $\frac{1}{2}$ | M. A.       | .....      | .....                                   | .....         |                                                            |
| 62  | Nov., 1889  | 65   | F.   | R. E. $\frac{1}{2}$ | Em.         | .....      | .....                                   | .....         | This condition is known to have been in existence 7 years. |
| 63  | Dec., 1889  | 53   | F.   | R. E. $\frac{1}{2}$ | H.          | .....      | .....                                   | .....         |                                                            |
| 64  | Dec., 1889  | 80   | F.   | R. E. $\frac{1}{2}$ | H. A.       | .....      | .....                                   | .....         |                                                            |
| 65  | Jan., 1890  | 79   | F.   | R. E. $\frac{1}{2}$ | M.          | .....      | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles    |                                                            |
| 66  | Feb., 1890  | 42   | F.   | R. E. $\frac{1}{2}$ | M. A.       | .....      | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles    |                                                            |
| 67  | Mar., 1890  | 71   | F.   | R. E. $\frac{1}{2}$ | H.          | .....      | .....                                   | .....         |                                                            |
| 68  | Mar., 1890  | 62   | F.   | R. E. $\frac{1}{2}$ | H. A.       | .....      | .....                                   | .....         |                                                            |
| 69  | Nov., 1890  | 70   | F.   | R. E. $\frac{1}{2}$ | M. A.       | .....      | .....                                   | .....         |                                                            |
| 70  | Nov., 1890  | 66   | F.   | R. E. $\frac{1}{2}$ | H. A.       | .....      | .....                                   | .....         | L. E. Advanced Cataract.                                   |
| 71  | July, 1890  | 41   | M.   | R. E. $\frac{1}{2}$ | M. A.       | .....      | .....                                   | .....         |                                                            |

| No. | Date.       | Age. | Sex. | Vision.                                 | Refraction.         | Last seen   | Vision.                                 | Treatment.        | Remarks.                 |
|-----|-------------|------|------|-----------------------------------------|---------------------|-------------|-----------------------------------------|-------------------|--------------------------|
| 72  | June, 1890  | 57   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M.                  | April, 1891 | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles        | L. E. Advanced Cataract. |
| 73  | April, 1890 | 70   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  |             |                                         |                   |                          |
| 74  | Oct., 1890  | 62   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  |             |                                         |                   |                          |
| 75  | July, 1890  | 57   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M.                  | Feb., 1893  | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles        |                          |
| 76  | July, 1890  | 38   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H. A.               | Oct., 1891  | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles        |                          |
| 77  | Aug., 1890  | 52   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H. A.               |             |                                         |                   |                          |
| 78  | Mar., 1890  | 59   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M. A.               |             |                                         |                   |                          |
| 79  | Sept., 1890 | 66   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M.                  | Oct., 1891  | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Caust. and Silica | R. E. Advanced Cataract. |
| 80  | June, 1890  | 66   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Em.                 |             |                                         |                   |                          |
| 81  | Sept., 1890 | 75   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H. A.               |             |                                         |                   |                          |
| 82  | Nov., 1890  | 68   | M.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M.                  |             |                                         |                   |                          |
| 83  | June, 1890  | 63   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M.                  |             |                                         |                   |                          |
| 84  | Nov., 1890  | 61   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M.                  | Feb., 1892  | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Caust. and Silica |                          |
| 85  | Aug., 1890  | 70   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  |             |                                         |                   |                          |
| 86  | May, 1890   | 57   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H. A.               | June, 1892  | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles        |                          |
| 87  | Sept., 1890 | 75   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H. A.               |             |                                         |                   |                          |
| 88  | Oct., 1890  | 41   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  |             |                                         |                   |                          |
| 89  | April, 1890 | 75   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M. A.               | Dec., 1892  | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles        |                          |
| 90  | Oct., 1891  | 70   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  |             |                                         |                   |                          |
| 91  | Sept., 1891 | 59   | M.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  |             |                                         |                   |                          |
| 92  | Oct., 1891  | 61   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  |             |                                         |                   |                          |
| 93  | Mar., 1891  | 68   | M.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M.                  | April, 1892 | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Caust. and Silica |                          |
| 94  | May, 1891   | 60   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M.                  | Feb., 1892  | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ |                   |                          |
| 95  | April, 1891 | 59   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M.                  |             |                                         |                   |                          |
| 96  | Mar., 1891  | 67   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H. A.               |             |                                         |                   |                          |
| 97  | April, 1891 | 64   | M.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H. A.               | April, 1893 | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ |                   |                          |
| 98  | Oct., 1891  | 72   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M. A.               |             |                                         |                   |                          |
| 99  | Jan., 1891  | 60   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  | July, 1892  | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Spectacles        |                          |
| 100 | Feb., 1891  | 64   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M.                  |             |                                         |                   |                          |
| 101 | Nov., 1891  | 68   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | (R. E. H. L. E. M.) |             |                                         |                   |                          |
| 102 | Nov., 1891  | 55   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | M. A.               |             |                                         |                   |                          |
| 103 | June, 1891  | 63   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  |             |                                         |                   |                          |
| 104 | Mar., 1892  | 67   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H. A.               |             |                                         |                   |                          |
| 105 | May, 1892   | 65   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  |             |                                         |                   |                          |
| 106 | April, 1892 | 58   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  | May, 1893   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | Caust.            |                          |
| 107 | July, 1892  | 60   | F.   | R. E. $\frac{1}{2}$ L. E. $\frac{1}{2}$ | H.                  |             |                                         |                   |                          |

In 1882 Mr. C. diagnosed Cataract in R. E. now advanced

| No. | Date.       | Age. | Sex. | Vision.                                 | Refraction. | Last seen. | Vision.                                 | Treatment. | Remarks.                     |
|-----|-------------|------|------|-----------------------------------------|-------------|------------|-----------------------------------------|------------|------------------------------|
| 108 | Dec., 1892  | 60   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |            |                                         |            |                              |
| 109 | Nov., 1892  | 73   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          |            |                                         |            |                              |
| 110 | Mch., 1892  | 56   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          |            |                                         |            |                              |
| 111 | Nov., 1892  | 59   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          |            |                                         |            |                              |
| 112 | Sept., 1892 | 70   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |            |                                         |            |                              |
| 113 | Jan., 1892  | 77   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          |            |                                         |            |                              |
| 114 | Jan., 1892  | 60   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M. A.       |            |                                         |            |                              |
| 115 | Jan., 1892  | 57   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |            |                                         |            |                              |
| 116 | Dec., 1892  | 71   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M. A.       |            |                                         |            |                              |
| 117 | April, 1892 | 68   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          | Feb., 1892 | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ |            | R. E. Amblyopic, old squint. |
| 118 | Mar., 1892  | 63   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | Em.         |            |                                         |            |                              |
| 119 | Jan., 1892  | 60   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          |            |                                         |            |                              |
| 120 | Feb., 1892  | 71   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          |            |                                         |            |                              |
| 121 | July, 1892  | 80   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | Em.         |            |                                         |            |                              |
| 122 | Oct., 1892  | 56   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          |            |                                         |            |                              |
| 123 | Mar., 1892  | 48   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          |            |                                         |            |                              |
| 124 | June, 1892  | 58   | M.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | M.          |            |                                         |            |                              |
| 125 | May, 1892   | 70   | F.   | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | H.          | Nov., 1892 | R. E. $\frac{1}{8}$ L. E. $\frac{1}{8}$ | Spectacles | R. E. Advanced Cataract.     |

## A CONTRIBUTION TO THE STUDY OF MASTOID DISEASE AND ITS COMPLICATIONS.

BY DUDLEY WRIGHT.

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THE subject of inflammatory conditions of the temporal bone, and their various secondary manifestations, is daily growing of more importance. During the past few years a voluminous literature treating of this matter has sprung up, and our knowledge of the pathology and surgical treatment of the various affections having their origin in morbid states of the middle ear has advanced by giant strides, equalling, if, indeed, not exceeding, both in extent and importance, the notable advances made in other departments of surgery. And a still further advance may be expected as time goes on; for, though we may view with some fair amount of gratification and satisfaction the extent of our present knowledge, so far as surgical procedure is concerned, we have yet much to learn in the direction of diagnosis.

Such being the case, it is scarcely necessary to plead that all those who are called upon to deal with cases of this nature should make a point of carefully recording the minutest symptoms which have been present, both during the attack, as well as for some time preceding the onset of the acute stage. It is obvious that only by doing this, and comparing them with the conditions revealed in the operating room, or the mortuary, that we can hope to obtain the desired knowledge.

Further, the light shed on this matter by recent research

has impressed on us the melancholy fact that much suffering and loss of valuable life, has been brought about by the utter indifference of the public, and the too often unpardonable neglect by the practitioner, of the treatment of what seems to him to be but a simple discharge from the ear. In such cases it is hard to say which of the two stands the more in need of education, the former to be taught to seek immediate medical advice and to rigidly carry out the treatment prescribed, or the latter to apply himself diligently to the cure of this disease, considered by him so trivial and scarce worthy of consideration, but which, alas, if neglected, is liable to lead to such dire results. It may, therefore, be deemed pardonable if at this point the one great lesson taught by the following cases is to some extent anticipated, and the golden rule emphasised—that no discharge from the ear, however small it be in quantity, and however free from annoyance to the patient, should, on any account, be unheeded or left to cure itself; for such a course can but reflect discredit on him who adopts it, and may result in the most evil consequences to the patient on whom it is practised.<sup>1</sup>

Inflammation of the mastoid, by which is meant inflammation of the lining membrane of the mastoid cells, with or without involvement, at the same time, of the overlying bone and periosteum, may be a primary or secondary disease. The former is a rare condition, and the secondary form—the only one considered in this paper—is usually the result of either acute or chronic suppuration within the middle ear.

The mode of transmission of the disease from this region to the mastoid cells will be made clear by referring to the figure of the adult temporal bone (fig. 1), in which it will be seen that the cavity of the tympanum is in direct communication with the so-called mastoid antrum A, which in its turn

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<sup>1</sup> It might be well to mention here that statistics show that at least one person per week dies in London of lateral sinus pyæmia alone, and inasmuch as this is but one of the complications of middle ear disease, it may safely be concluded that the death-rate is yet higher when we include the cases of the other complications,

opens into the adjacent mastoid cells. The size and number of these cells varies within wide limits, and, like the mastoid process itself, they are absent at birth, and only appear later, during the development of the pars mastoidea of the temporal bone. This is clearly seen in figures 2 and 3, which depict the condition of the bone at birth and at puberty respectively. In the former the mastoid process has not yet appeared; in the latter it is present, and there are some cell-spaces in its substance.

In both bones, however, a well-marked mastoid antrum is present (A). This space is, so to speak, a fixed quantity, and may be reckoned on being present in all cases, and at every age of life. On the external surface of the head its position may be marked by a point taken from  $\frac{1}{3}$  to  $\frac{1}{2}$  an inch above and behind the centre of the bony meatus. In many cases, however, it is not necessary to make these measurements, as the spot may, with comparative certainty, be found by tracing the anterior border of the mastoid upwards until a tubercle is felt a short distance above the meatus, *i.e.*, at the anterior superior part of the mastoid. This tubercle, known as the spina supra meatum, has below it a well-marked depression, which is usually present, even if the spine be absent, and perforation of the bone at this spot, in a direction inwards and slightly forwards, will open the antrum.

Inasmuch as other important structures, in close proximity to the mastoid cells and antrum, are in danger of participating in the process of disease; it will save repetition if we here enumerate the chief anatomical points in connection with them.

First, and most important, is the lateral sinus which, lying as it does in the groove on the inner surface of the mastoid, is particularly liable to become the seat of septic processes. The course taken by the sinus is indicated on the exterior of the skull in fig. 6 (dotted line), and its relationship to the mastoid and external meatus is shown in figs. 4 and 5.

It will be seen that to expose it from the exterior, it will be necessary to chisel away the bone behind the position of the antrum, and it may be added that there need, in operating

on the living body, be no fear of cutting away too much bone, as it requires the removal of a considerable sized piece to allow of a thorough exploration of the sinus, and give exit to pus when it is present. Likewise, injury to the sinus itself is not of serious consequence, for the hæmorrhage is easily controlled by plugging. It is also of importance to remember that the superior petrosal sinus, running along the upper border of the petrous portion of the temporal bone, is connected at one end with the cavernous, and at the other with the lateral sinus; and, further, that into it several of the veins from the middle ear, from the temporo-sphenoidal lobe, and lateral lobe of the cerebellum, empty their contents. It is, therefore, plainly seen how septic matter can travel from the tympanic cavity to the lateral sinus, and having set up a septic phlebitis therein, and aided by such factors as cause the detachment of portions of the clot thus formed, favour the early occurrence of a general pyæmia.

The next structures to be considered play a scarcely less important part in the disease than those with which we have just dealt.

It will be remembered that the upper surface of the petrous portion of the temporal bone forms a part of the floor of the middle fossa of the skull, and that its posterior surface is one of the boundaries of the posterior fossa, parts occupied by the temporo-sphenoidal lobe and the under surface of the lateral lobe of the cerebellum respectively, and, as fig. 3 shows, the cavity of the tympanum is separated from the middle fossa by a mere lamina of bone which would be easily perforated by caries. These facts, combined with those mentioned above concerning the cerebral veins, give us an insight into the causation of the abscesses met with in the brain substance, which, in connection with ear disease, are but seldom located in parts other than the two above mentioned.

In the last place, the meninges, occupying a mid position between the venous sinuses and the brain, may, in their turn, become the seat of disease, either singly or in conjunction

with one or more of the other lesions above named. The pus formed here may rest beneath the dura mater and in the meshes of the pia mater, constituting a true septic meningitis, or it may be pent up between the dura and the bone, thus forming an extra-dural abscess, which, in all cases, tends to burrow in the direction of least resistance, and in accordance with the laws of gravitation; the course taken being usually towards the posterior surface of the petrous bone and around the sulcus lateralis.

The following, then, are the complications<sup>1</sup> met with in the course of suppurative disease of the middle ear: 1, supuration in the mastoid antrum and cells (mastoid empyæma); 2, thrombosis of the lateral sinus and sinus pyæmia; 3, extra dural abscess; 4, septic meningitis; 5, cerebral abscess; 6, cerebellar abscess.

Having thus cleared the ground and studied the question from an anatomical and pathological standpoint, we may now, by examining case-narratives of the various complications, look at the subject from a clinical point of view.

#### I.—MASTOIDITIS AND EMPYÆMA OF THE MASTOID.

CASE I.—J. C., a married woman, aged 22 years, when first seen, was complaining of pain in the left ear, mastoid region and neck, offensive discharge from the ear, and general feeling of weakness. Her history was that, when 7 years old, she had an abscess in the left ear, following an attack of measles. It was not treated but ceased to discharge in a few weeks, leaving behind it a considerable amount of deafness, which had not since improved. About two years ago the ear began to discharge again, and has done so, on and off, ever since. About the same time as the second onset of the discharge, she noticed the vision of the left eye indistinct, and this likewise has continued to the present time. She had also

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<sup>1</sup> It must be understood that it is by no means rare to find more than one of these complications present at the same time.



noticed that of late she had become much paler, and for the past four months the catamenia had ceased. Four days ago (Nov. 6, 1892), the ear suddenly ceased to discharge, and the following night she was attacked with severe pains of a shooting character on that side and in the back of the head. Examination of the ear showed the external meatus full of inspissated pus, and on removal of this, it was seen that the greater part of the membrana tympani was absent, the lower edge of the perforation being thickened and studded with granulations. The inner wall of the cavum tympani was of a pearly white colour. At the upper margin of the tympanic ring was seen the malleus much shorter than usual. The incus and stapes could not be seen.

There was tenderness on pressure over the mastoid and temporal region, and also down the course of the sterno-mastoid. Marked anæmia was present, and there was a systolic bruit over the mitral region. Lungs and kidneys normal. Several teeth were in an advanced state of decay, and the digestive system was much upset. She was admitted to the hospital and treated with hot fomentations over the mastoid, with local application of glycerine and belladonna, frequent irrigation of meatus with warm antiseptic lotion, and bell. and merc. iod. internally. During her stay in the hospital the temperature did not rise much, and the patient soon improved, though a few relapses of the pain and inflammatory symptoms occurred. The teeth were extracted, and she received, latterly, treatment for the anæmia. The patient left the hospital in a month, with no pain and only a slight discharge which ceased two weeks later.

The above may be taken as an illustration of an attack of mastoiditis, which, taken in an early stage, subsided under suitable treatment. The sudden cessation of a discharge with the appearance of pain and *tenderness on pressure* over the mastoid, are the two cardinal symptoms of an attack of mastoiditis. Cessation of the discharges, with the occurrence of pain over the temporal and mastoid regions without tenderness to pressure, of themselves do not, of necessity, imply mastoid inflammation, as the following case shows :—

CASE II.—I was asked by Dr. Burford to examine the ear of one of his patients in the Gynæcological Ward, who had for some days been suffering from a discharge from the right ear, which had ceased more or less suddenly, synchronously with the onset of pain in the mastoid and temporal regions. On examination, I found that, although there was great pain, there was no tenderness to pressure over these parts; and, on looking into the ear, I found a small cicatrix of the drum membrane, which had evidently only recently formed over a perforation, the rest of the drum-head being, to all appearance, normal. It was, therefore, probable that this patient was suffering from neuralgia, which had its origin in some other cause than an inflamed mastoid; and the result of treatment fully bore out this supposition.

Inflammation of the mastoid usually produces in children more swelling of the external tissues than in adults, particularly if pus has already formed; since, in the former, it will find a far easier exit through the bone. An abscess may, however, be present over the mastoid, or a short distance below it, without being exactly in direct connection with the interior of the bony structures; and such conditions are attributable to an infective inflammation of the gland which is situated in those regions. The two following cases are examples of pure mastoid abscess, and abscess due to adenitis respectively.

CASE III.—A little boy, aged 5, suffering from active hip joint trouble, and a chronic purulent discharge from the right ear, with occasional attacks of pain therein (for which he had been receiving treatment, in the form of daily irrigation of the meatus and occasional inflation with air), suddenly developed one night a smooth, diffused, red, and painful swelling behind the auricle, which rapidly increased in size, pushing the auricle forwards, and at the same time extending over to the front part of the face, and into the external meatus, which was nearly closed by it. These symptoms were accompanied by considerable increase of the temperature, already elevated by the hip disease, and much nausea and sickness. The pain being acute, and the condition grave, it was deemed advisable

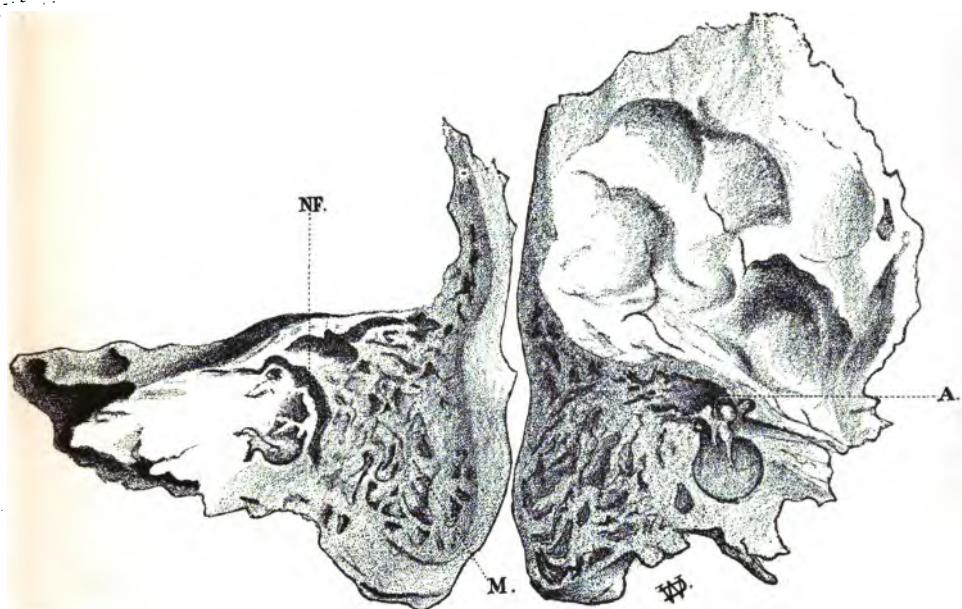


FIG. I.—Temporal bone of an adult divided so as to show the tympanum and mastoid cells.

A.—Mastoid antrum.

M.—Mastoid cells.

NF.—Canal of facial nerve.

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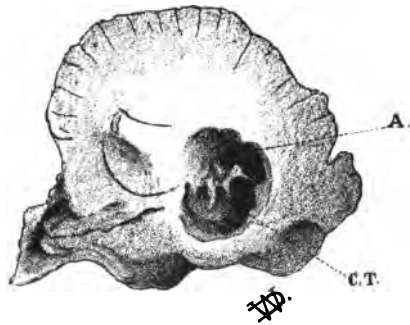


FIG. II.—Temporal bone of a new born child. The annulus tympanicus has been removed, together with a portion of the bone to which it is attached, in order to show the tympanic cavity (C.T.) containing the ossicles, and the antrum (A.) leading upwards from the middle ear. It is to be noticed that no mastoid process exists.

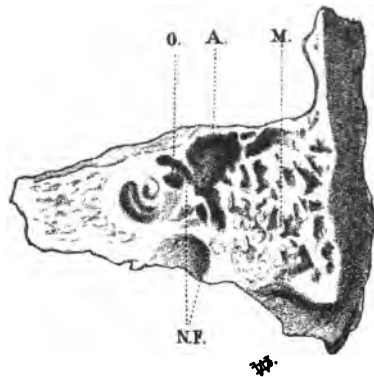


FIG. III.—Temporal bone of a child, aged 14 years, divided longitudinally.

A.—Mastoid antrum.

M.—Mastoid spaces (larger than is usually the case).

NF.—Canal of facial nerve.

O.—Foramen ovale.



to incise the swelling and give exit to the pent-up matter without further delay. This was done under induced anæsthesia; and a large quantity of foetid pus escaped, the incision being carried through the tissues to the periosteum underlying, and into the bone which was so thinned by the excessive tension, that it scarce offered any resistance to the knife. A probe passed through the opening thus formed, in a direction forwards and inwards, entered the middle ear. A thorough scraping away of all carious bone and washing out the *débris*, completed the operation. The dressing consisted of a small drainage tube, and a boracic fomentation which was renewed every few hours. The little patient, on recovering from the effects of the anæsthesia, expressed himself as free from all pain, though the vomiting continued for some hours, and was ultimately checked by the administration of *ipéc.* The swelling around the mastoid rapidly subsided; the tube was removed in a few days; and in eighteen days from the date of the operation the external wound had healed. There was still, however, some discharge from the ear which had not yet ceased 2½ years later. This is hardly to be wondered at, as the boy is in a very poor condition, with well-marked tuberculous disease present in other parts of the body, and it is highly probable that the otorrhœa partakes of the same nature.

In the above case, no doubt could be entertained as to the origin of the abscess; the communication through the bone with the mid-ear being evidence enough. In the next example of abscess in the mastoid region, though we have signs of mastoiditis and the presence of pus in the tissues in its vicinity, there is nothing which would lead to the conclusion that the phenomena had any but an indirect association.

The following is the history :—

CASE IV.—Elizabeth W., aged 14, was admitted to the hospital on August 8th, 1890, for pain in the right ear and swelling around the mastoid. She had a "gathering" in the left ear four years ago, but this soon got well, and up to the present attack had no trouble with the right ear. The present illness came on one month ago; there was great pain for

some three days, and this was followed by discharge from the ear. Four days ago she noticed a swelling behind the ear which was tender to touch and increased gradually in size. Beyond the above local symptoms, there were but few signs of general illness. Behind the right ear, in the mastoid region, was a localised swelling about the size of a crown piece; the skin covering it being red, shining and tender. Obscure fluctuation was present. On the following day the swelling was incised under chloroform, the incision being made through the periosteum. The bone was intact, but just below the mastoid, in the deep tissues, was a small cavity containing pus. This was evacuated and the cavity scraped out. The wound discharged for two days, and then quickly healed up. The ear likewise ceased discharging before the patient quitted the hospital, which was seventeen days after admittance. At this date the following note was made:—  
“The external wound quite healed, and no swelling or tenderness present. The membrana-tympani is dull, but not swollen; the malleus handle being rather indistinct, and behind and parallel to it there is a linear cicatrix, the edges of which are vascular.”

An interesting example of abscess in the mastoid region, which was lately sent to my out-patient department as a case of mastoid disease, might be mentioned here without irrelevancy. The patient, a young woman in a weak and emaciated condition, had suffered for two weeks from a swelling behind the left ear, which, when I saw her, was the size of a bantam's egg, and presented marked fluctuation. There was no sign of disease of the middle ear, and examination soon proved that the symptoms were due to suppurative adenitis, caused by pediculi capitis. About two ounces of pus were evacuated, and the cavity thus formed, together with the peripheral ring of indurated tissue, much resembled that caused by considerable loss of bone. Under treatment directed towards the apparent cause, the wound healed within ten days.

Before leaving the subject of abscess in the mastoid region to consider the deeper-seated forms of inflammation, it may



be well to review a few of the points in connection with the former disease. We have seen that in children whose mastoid cells have not developed, the mastoid antrum is the only cavity intervening between the middle ear and the external plate of bone. It is in this recess that the products of inflammation tend to accumulate, and by absorbing the bone which forms the outer wall of the cavity, find an exit at the upper part of the mastoid, just behind the meatus externus. In adults, however, the mastoid cells being present may become filled with pus (empyæma of the mastoid). And in such cases if perforation occurs at all, it may take place either through the outer plate of bone as in children, though usually at a somewhat lower level, or the pus may make a way for itself through that part of the inner aspect of the process which forms the outer boundary of the fossa of the digastric muscle, and then, following that structure forwards and downwards, present as a fluctuating swelling beneath the deep fascia in front of the sterno-mastoid, and finally tend, if left unopened, to gravitate to the lower part of the neck. This form is uncommon, though well recognised, and demands early interference in the way of evacuating the abscess and ensuring free drainage of the same, and removal of the whole of the mastoid process, in order to get rid of the carious bone on its inner aspect and the cellular spaces which constitute one of the seats of the disease ; at the same time it is necessary to expose the antrum and middle ear and thoroughly cleanse out their cavities. It is surprising how little the hearing is interfered with after such operations ; indeed, it is commonly noted that audition is distinctly improved, even though the greater part of the drum membrane and the malleus and incus have been removed.

There is yet another way in which pent-up pus may make its escape outwardly, viz., through the posterior wall of the external bony meatus. It will be seen, by referring to fig. 4, how close a relation this bears to the mastoid cells ; and it will be remembered that in Case III. such a communication actually existed, and we shall again have occasion later to notice its occurrence in other cases (Cases VII. and X.).

In dealing with inflammatory states of this region, we have often to ask ourselves the question whether or not an incision of the tissues is called for. When there are distinct indications of pus being present, I cannot myself see any reason why it should be left to accumulate, and should, therefore, incise early and be guided by the condition of the bone and surrounding tissues as to what further measures to adopt. Many cases of mastoid abscess have undoubtedly been treated without incision and have subsided without bursting externally, and thus given rise to the supposition that the pus has been absorbed; but I believe that were we to closely examine these cases, it would be found that the pus had obtained an exit either through the external meatus or through the Eustachian tube into the pharynx, or even that in many cases no abscess existed, the brawny swelling having been due to a periostitis of the region in connection with some inflammatory condition, *e.g.*, furuncle of the outer meatus; for it must be remembered that, inasmuch as the periosteum lining the meatus and covering the mastoid are continuous, inflammation of the one part may lead to a similar condition in the other.

Advising incision in cases where pus has already formed, by no means implies the recommendation of a similar course when the symptoms present point to a simple periostitis or otitis. Doubtless such treatment will here often give great relief by relieving tension, and may even prevent suppuration; but I think we have in such drugs as *aconite*, *belladonna*, *gelsemium*, *mercurius* and *veratrum viride*, ample means for cutting short the attack. Patients who do not rapidly improve under the administration of the suitable medicine, are generally in need of a more extensive operation than simple incision, for it will be found that the symptoms present are but the outward and visible signs of a deeper-seated trouble.

It is worthy of note, that patients often date the first appearance of the mastoid symptoms from the sudden stoppage of the discharge from the ear. It is highly probable that, in many cases, these two occurrences stand in the relationship of cause and effect to one another. One meets occasionally

with marked instances of this, some mechanical obstruction to the outflow being found, which is sufficient to dam back the purulent discharge, and force it to enter and excite inflammation in the adnexa of the middle ear. Of such a nature is the following.

CASE V.—Edwin D., aged 21 years, complained of great pain and swelling behind the left ear, which had come on during the past three days. He gave the following history. The left ear had discharged ever since infancy, with but few intermissions. Four years ago, the discharge stopped suddenly, and a swelling formed behind the ear. This was lanced, and a quantity of pus escaped. The patient had noticed that the discharge had suddenly stopped, on the present occasion, before the swelling formed behind the ear.

The left auricle was pushed forwards by a red, œdematous, non-fluctuating swelling in the mastoid region. The external meatus was plugged with a piece of wool; and, on removal of this, I found a second plug packed deeply into the passage which must have lain there for a considerable time, as the patient was totally unaware of its presence; and it was saturated with intensely foetid pus. This was removed; and inspissated pus in large quantity was syringed away, and the patient was ordered *merc. bin. iod.* and frequent irrigation of the ear with an antiseptic lotion. The patient failed to return for further treatment.

We have, hitherto, been considering only those cases in which disease within the temporal bone manifested itself outwardly by well-defined signs. There is, however, another class in which, though deep-seated disease of the bone be present, the external and obvious signs are by no means unequivocal.

In cases of this nature it is usually found that the long-standing inflammation within the tympanum and its adnexa has produced a sclerosis of the overlying bone; the cellular spaces of the mastoid being thereby obliterated, and the osseous tissue transformed into a compact mass of ivory hardness.

This state of things will evidently form an insurmountable

obstacle to the pus making an outward exit by any other route than a pathological perforation of the tympanic membrane; unless, indeed, as is not seldom the case, a small fistulous opening exists in the posterior bony wall of the external meatus, leading from the neighbouring seat of disease. In either case the aperture will probably be insufficient, and the risk of the septic products finding a pathway in other and more dangerous directions will be increased manifold: the risk increasing in direct proportion to the diminution of the size of the aperture.

Having now but few external objective signs to guide us, we are compelled to base our diagnosis mainly upon the nature of the discharge from the ear, if there be any; the presence of bony particles being, of course, diagnostic; the presence of fistulæ in the external meatus; and such subjective symptoms as pain, tenderness to pressure or percussion over the mastoid region—which it is correct to say may be entirely absent—and attacks of vertigo.

Further, facial paralysis of the same side as the diseased ear, though highly suggestive of bone involvement, is by no means a certain guide. It is generally recognised that such a condition may occur as the result of pressure exerted upon the nerve by an inflammatory exudation within the Fallopian canal, or even by a similiar collection of fluid within the tympanum, acting either through the thin, bony wall of the canal, or a congenital defect in that wall.

The following two cases are illustrations of this condition of deep-seated trouble, without obvious external symptoms:—

CASE VI.—Nellie B., aged 9 years, was admitted to the hospital towards the end of 1891, suffering from offensive purulent discharge from the left ear, accompanied by considerable deep-seated pain in the mastoid region. A perforation was present in the postero-inferior segment of the drum-head. The discharge ceased, the pain disappeared, and the perforation healed under treatment, and the patient was discharged from the ward. Some three months later she was brought to the outpatient department with very similar symptoms. *Silica* was

ordered internally, and a weak iodine solution for irrigating the meatus. The patient continued this treatment for a month, and was then seen again, the purulent discharge being less in quantity, though just as offensive as before.

For the next three weeks she was seen weekly, the remedies used being *arsenicum alb.*, and *iodidum* and *sanguinaria*. As there was no real improvement, and latterly the deep-seated pain had increased, and occasional hæmorrhage from the ear and nose had taken place, the patient was re-admitted to the ward in order to be more carefully kept under observation. The improved surroundings failing to produce the desired amelioration, it was decided to explore the tympanic cavity and antrum by a mastoid opening, and accordingly the patient was anæsthetised, and the operation performed by trephining a short distance and removing the succeeding layers of bone with a gauge. The bony tissue was of extreme hardness, and a greater thickness had to be perforated than was natural in a child of her age, and in removing the deeper layers the cranial cavity was accidentally opened, and the dura mater bulged slightly into the wound. As the antrum had not been reached the operation was discontinued in order to allow the accidental perforation to be sealed up with granulations before proceeding further. A few days sufficed to accomplish this, and, therefore, at a second operation, the tunnel toward the antrum was deepened, the antrum reached, and that cavity, together with the tympanum, thoroughly scraped out and cleansed with an antiseptic lotion, the fluid finding an exit through the meatus. A gauze drain was inserted into the opening, and the usual dressings applied. Convalescence was uninterrupted, the sinus gradually ceasing to discharge, and healing up slowly, the patient leaving the hospital with only a small wound, which did not communicate with the tympanum.

By the end of a few months the patient was quite well. In the following year she was seen once again, as there was a discharge from both ears, due to an eczematous condition of the meatus, which rapidly disappeared under treatment, and

when seen a few weeks since the patient was in excellent health, and had no trouble with the ears.

CASE VII.—Miss H., sent to me by Mr. Gerard Smith, had suffered from an offensive purulent discharge from the right ear for about a year. She had also been subject to repeated attacks of severe pain in the mastoid region, accompanied at times by vertigo.

As a child she had been subject to ear-ache, and tuberculous abscesses had formed in various parts of the body, but were now healed. A short time before the onset of the present illness an abscess had formed in the pelvic region—probably a pyosalpynx—which had ruptured externally per vaginam.

There was absence of any swelling over the mastoid, though there was tenderness to pressure over the part. The vision was unaffected, the facial nerve intact, and tinnitus was not complained of. After removing some inspissated pus from the meatus, a small conical granulation was found on the posterior wall, a short distance from the drum-head, and a small fistula existed on its summit, which admitted the bent extremity of a fine probe. The part of the wall intervening between the granulation and the drum-head was bulged forward, and of red colour. The drum membrane was thickened and red, the malleus being invisible, and there was, so far as could be seen, no perforation present.

The patient could hear the watch on the right side, at a distance of 1 in., on the left at 6 feet.

It was considered advisable, as internal medication had failed to produce sufficient alleviation of the symptoms, to give free exit to the pus by an opening behind the ear, and, at the same time to remove as much of the carious bone as was possible.

The patient having signified her willingness to undergo the operation, this plan was accordingly adopted.

The steps of the operation were similar to those already described. The bone was found markedly sclerosed, inso-much so that the points of three chisels were chipped in

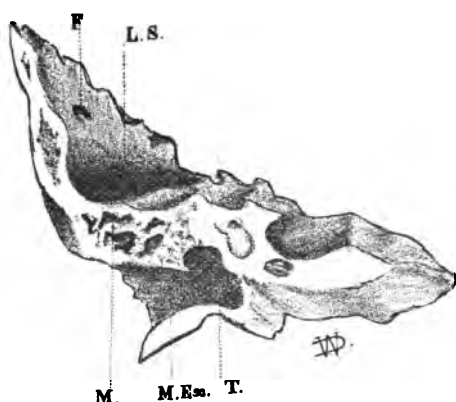


FIG. IV.—Horizontal section of the squamous and petrous portions of adult temporal bone : lower half of section viewed from above.

L.S.—Groove of lateral sinus.

F.—Foramen for transmission of mastoid vein.

M.—Mastoid cells.

M.Ex.—Meatus externus.

T.—Cavity of the tympanum.

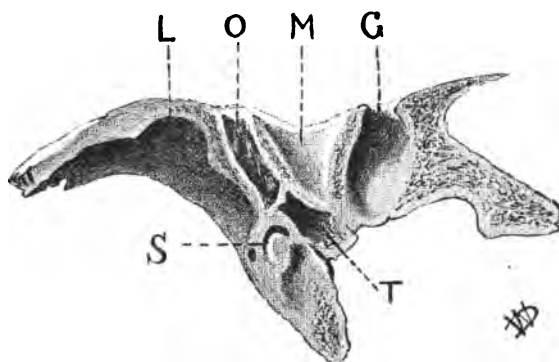


FIG. V.—Upper half of horizontal section of adult temporal bone, made at a level somewhat above the centre of the external meatus, and viewed from below.

G.—Glenoid cavity.

L.—Groove of lateral sinus.

M.—External meatus.

O.—Opening made behind external meatus towards the antrum (T.) from which it is separated by a narrow bridge of bone, over which the bent probe is hooked. (See description of the operation).

S.—External horizontal semi-circular canal. (Its relation to the antrum and external opening is clearly seen).





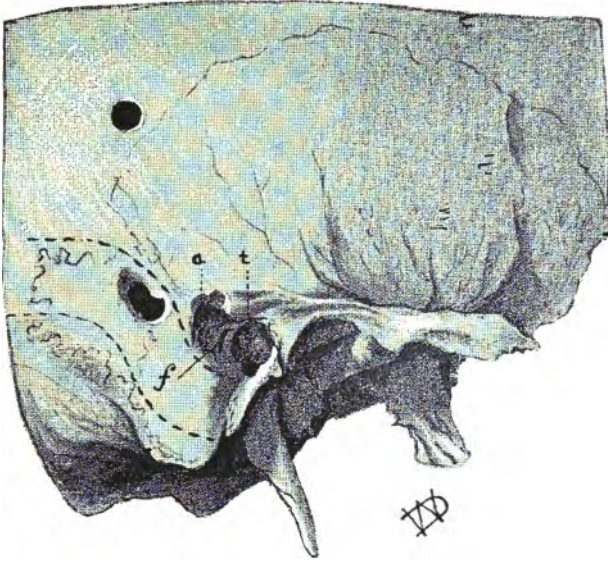


FIG. VI.—Part of the right side of skull of adult, including the whole of the temporal bone.

An opening has been made into the antral cavity (a), and between it and the cavity of the tympanum (t) is seen the canal of the facial nerve (f) intentionally opened.

Behind is a curved dotted line indicating the course taken by the lateral sinus, and a part of the bone covering it has been removed as in the operation.

Above this is seen a circular trephine opening made about  $1\frac{1}{4}$  inch behind the centre of the bony meatus, and  $1\frac{1}{4}$  inch above Reid's base line indicating the spot for trephining for exploration of the temporal lobe of the brain.



cutting through it. This condition considerably prolonged the operation, but an opening was finally made into the antrum, which was smaller than natural, and some carious bone and granulations scraped away, and the incus removed; this ossicle showing a loss of substance (caries?) of the part which articulates in the stapes.

The patient recovered from the operation fairly well. There was a good deal of vomiting, which lasted on and off for two days, and recurred later on. (The patient had been for some years subject to such attacks.) The temperature was raised at night to 99°, but fell finally by the fourth day. At a subsequent dressing it was noticed that the cranial cavity had been opened in the operation, there being a small, slit-like opening through which the dura mater could be seen pulsating. On the eighteenth day after the operation, the patient was able to walk in the open air, and was wearing a small, vulcanite plug in the sinus. There was no discomfort or pain in the ear, except when the patient lay on the diseased side, and the plug was pressed upon. The discharge had lost its offensiveness, and was no more in quantity than would be caused by the granulations springing up around the cavity. The patient is still under treatment (twenty days after the operation).

Before passing on to consider the remaining complications, it will be well to state briefly the method employed to obtain free access to the parts in question.

In my former cases, a trephine was used to remove the greater part of, if not all, the bone forming the outer wall of the antrum; but I have lately used only the chisel for this purpose, as I believe that with this instrument we are better able to proceed with exactness and caution. And whereas, it was formerly my custom to be content with having drilled a small opening into the antrum and cleansed out its contents through this, I am now careful to remove all bone lying between that cavity and the external meatus, which is virtually the posterior bony wall of the latter (fig. 5), so that one large cavity is thereby made (formed by the combined

antral and tympanic cavities together with the meatus externus). Free drainage is thus obtained ; and the wound must be allowed to heal up from the bottom.

The steps of the operation are as follows :—

An incision is made behind the ear down to the bone following the insertion of the auricle. The edges being well retracted and the auricle held forwards, the lining of the meatus is then stripped off in the whole of its extent, from the posterior wall of the bony canal, and this likewise held forward.

A probe, bent to a small hook at its termination, is passed along the meatus, between the lining and the bony wall, into the antrum (which lies in an upward and slightly backward position) and made to hook, by means of its bent extremity, over the bridge of bone separating the cavity from the external meatus (*v.* fig. 5), and is held in this position by an assistant, or the anæsthetist. The point of the probe being in the antrum, will be the guide upon which to work ; and the bone can be now chiselled away in successive layers until the cavity be opened and the narrow bridge of bone supporting the probe removed.

By this means, the desired communication between the various parts of the middle ear and the exterior is effected ; and it remains now merely to remove as much of the mastoid process itself and the contained cells as shall be found necessary in each case ; and finally, to scrape away all carious bone and granulations from the cavity thus exposed ; in doing which, it not uncommonly occurs that the incus and malleus come away with the *débris*.

The whole area of the operation having been thoroughly cleansed, the flap of skin lining the meatus, which has, hitherto, been held forwards, is now divided longitudinally, and the two portions separated and made, so far as is possible, to line the cavity ; and a pledget of iodoform gauze both in the external meatus and the wound complete the proceeding. At subsequent dressings, the wound should be thoroughly cleansed by injecting the fluid in through the posterior opening, and

making it return by the meatus. A plug of vulcanite or lead —both of which are more suitable for the purpose than a simple indiarubber drainage tube — should be kept in the wound so as to prevent the external opening from healing, until granulations, springing up from below, have sufficiently sealed up the deeper parts to render it safe to allow the opening to close ; and daily irrigation with some efficient antiseptic strictly enforced.

It should be mentioned that, during the operation, an electric search light is of the greatest assistance in illuminating the depths of the wound.

During the operation, one or more of the following accidents may occur :—

1.—Opening the cranial cavity, usually the middle, sometimes the posterior fossa of the skull.

2.—Injury to the horizontal semi-circular canal, which lies in close proximity to the inner wall of the mastoid antrum (see fig. 5, S.).

3.—Injury to the facial nerve in its course downwards towards the stylo-mastoid foramen (figs. 1 and 3 N.F. and fig. 6 f.).

4.—Injury to that part of the lateral sinus which lies on the inner aspect of the mastoid process (figs. 4 L.S. and 5 L.).

If the operation be performed as above described the last-named accident can scarcely occur, except during a too vigorous removal of the outer-lying parts of the mastoid process.

Injury to the facial nerve is best avoided by taking care not to cut away too much of the lower segment of the posterior wall of the meatus.

Opening the cranial cavity is probably the most common accident, as one naturally tends to work upwards whilst removing the bone in order to avoid injuring the facial nerve, and thus the risk is constantly run of opening the middle fossa. Fortunately, however, this is the least serious accident, and need not, as we have already seen, complicate matters to any serious extent, provided the dura mater be uninjured.

In order to avoid injuring the semi-circular canal one should be careful not to penetrate the bone in search of the antrum, should that cavity not be found, to a depth greater than three-quarters of an inch. If the operation be performed as above, one can scarcely fail to find the antrum, and in such a case the only precaution to take is to handle the inner wall of the cavity as gently as possible.

Should the lateral sinus be accidentally opened there will be considerable hæmorrhage, but this can be checked by plugging the opening, or by means of pressure forceps.

The patients usually bear the operation well, and but rarely any reaction occurs, though it must be confessed that in a certain small percentage of cases symptoms of septicæmia, and even pyæmia, occur, owing to the escape into the circulation of products of decomposition and infective organisms which have long lain within the diseased area, and for which the operation has, so to speak, afforded a pathway into the blood stream. Such an accident as this is, however, liable to be met with in any case where we have to deal with purulent matter pent up within bone, and it should not deter us from making the operation as complete as possible by removing all the diseased tissue which lies within our reach.

## II.—THROMBOSIS OF THE LATERAL SINUS AND "SINUS PYÆMIA."

We have already seen how close a relationship exists between the lateral sinus and the middle ear, not only in so far as their proximity is concerned, but also—and in the present connection this is the more important—in the fact that it is by means of the former channel that the venous blood, returning from the tympanum, finds its way into the general circulation. In certain cases, especially those in which there has been much necrosis of the part of the mastoid in immediate connection with the vein, we find that the long-continued inflammation has caused a hyperplasia of the coats of the vessel to such an extent even as to obliterate its lumen. A

natural barrier to the ingress of infective matter is thereby raised, and we shall have occasion to note this occurrence in one of our cases (Case X.); though, as we shall then see, this did not prevent the supervention of one of the previously-named complications.

The following is an example of septic phlebitis followed by pyæmia.<sup>1</sup>

CASE VIII.—Florence F., aged 12, first seen on October 20, 1891, was at that time complaining of severe pain around the right ear, radiating over the whole right temporal region; slight offensive brown-coloured discharge from the ear, and general feelings of malaise. The discharge had been present three years; one year ago the patient had an attack of scarlet fever, after which the discharge slightly increased. The pain came on for the first time three days ago; two days ago the patient vomited once and had a slight fit, but nothing definite was noticed about it beyond that the arms "twitched" a great deal, and that there was no loss of consciousness. On the day that she was first seen, the temperature was 101.6°. The mind was quite clear, though the child was evidently suffering great pain. Skin dry and tongue coated; pupils equal. There was no redness or œdema over the mastoid process, but this and the right temporal region were tender to pressure.

The next day, October 21, the patient was admitted to the hospital, the above symptoms remaining about the same. Examination of the meatus showed it filled by florid granulations, which completely obscured all view of the drum, and bled readily when touched with a probe.

In spite of treatment the patient grew rapidly worse. The pain increased; the temperature varied between 103° and 99.6° (see chart); the pulse became very frequent, at times reaching 150 per minute; there was great restlessness; the

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<sup>1</sup> This case was reported more fully in the *Monthly Homœopathic Review*, vol. xxvi., No. 1, and the account is taken from the notes of Drs. Cook and Rowland Wilde.

patient grew dull and was constantly sighing and moaning involuntarily; and there was photophobia. Ophthalmic examination revealed a commencing double optic neuritis.

On the third day after admission (October 24) the mastoid antrum was opened by means of a small trephine. About a drachm of fœtid pus was removed, and the granulations and polypi were removed by means of a curette. Iodoform emulsion (glycerine and iodoform) was then instilled through the mastoid wound, and a drainage tube and iodoform gauze dressing applied.

The operation had the effect of relieving the pain for about 24 hours. There was a free discharge from the wound, necessitating a change of dressing twice daily. The pulse, however, did not diminish in frequency, and the temperature showed oscillations.

On the morning of the 26th, the patient had a rigor, and the pain returned, and the optic neuritis was found to have increased. A consultation was held, and it was decided to explore the brain for an abscess. The spot selected for trephining was  $1\frac{1}{4}$  inches behind the centre of the meatus, and  $1\frac{1}{4}$  inches above Reid's "base line" (a line prolonged backwards from the lower and outer angle of orbit through the centre of the bony meatus). At this spot a  $\frac{1}{4}$  inch trephine was applied, the bone removed, and dura mater incised. An aspirating needle was then passed into the underlying temporal lobe in various directions, but no pus was found. The wound was, therefore, closed. A few small pieces of the bone removed were replaced, and the usual dressings applied, the pericranium and the skin flaps being sutured separately.

The patient recovered well from the immediate effects, and passed a good night, the temperature having fallen considerably, but the following day the symptoms returned, and the patient grew rapidly worse, being at times unconscious, and having daily rigors up to the 29th, the temperature on one occasion rising as high as  $107^{\circ}$ .

At midnight on the 29th it was decided, as a last resort, to explore the surroundings of the lateral sinus. To effect



this, an incision was made at right angles to the previous mastoid wound, and the bone removed just behind the mastoid process with a chisel, until the sinus was brought to view, and a further enlargement of the opening was then made with bone forceps. A probe passed backwards, separating the sinus from the bony groove gave exit to foetid pus. This was done several times, both upwards and backwards, and in the direction of the superior petrosal sinus, and along the posterior surface of the petrous bone ; and weak carbolic

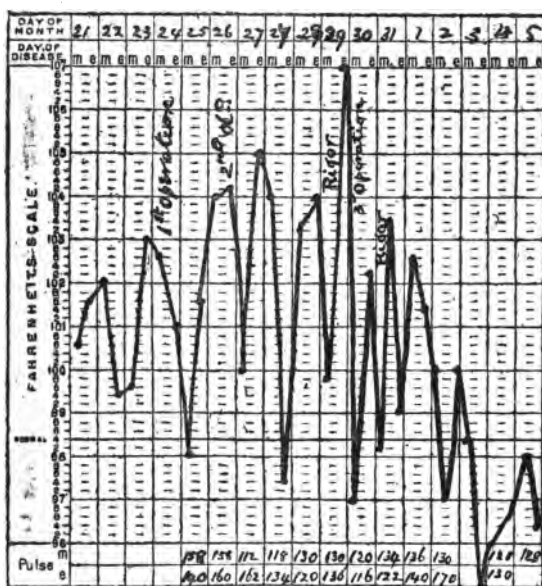


CHART I.

Case of septic thrombosis of lateral sinus with pyæmia (Case VIII.).

solution used to wash away the pus, which came away in fair quantity. The lateral sinus pulsed, and therefore appeared to have fluid contents, but it was not opened to ascertain this. The walls were rough, and covered in parts with inflammatory lymph.

The temperature fell to 97° after the operation, and

during the next day did not rise above  $102^{\circ}$ . The following day—October 30—the patient had another rigor. Temperature  $102.4^{\circ}$ . The general condition was fair. The wounds looked fairly healthy, and the discharge had entirely lost its offensive character. The patient suffered no pain, and slept and took food well. Dressings were renewed twice a day, and the antiseptic lotion was syringed for a considerable distance beneath the dura mater.

On November 1 the patient became worse. A cough developed, and she had pain in the left side of the chest, where a distinct friction sound was heard. This continued, and the strength gradually failed, and temperature fell, on one occasion going as low as  $95.2^{\circ}$ ; and finally the patient died on November 5, a week after the last operation. Bryonia, china, aconite, and lachesis were all used during the progress of the case, but without avail.

At the autopsy, extensive thrombosis of the lateral sinus of the right side was found, the clot extending downwards in the internal jugular vein as far as the level of cricoid cartilage, and upwards as far as the torcular herophili. The veins leading from the lateral and petrosal sinuses were extensively thrombosed. There was no abscess in any part of the brain, and no appreciable meningitis.

The roof of the mastoid antrum was necrosed and carious, and the ulceration had spread up to the petro-squamous fissure, thus effecting a communication between the tympanum and the sub-dural space.

A septic infarct was found in the right lung, the left lung was collapsed, and the pleural cavity contained about  $\frac{3}{4}$  i. of pus. The other organs were fairly healthy. The trephine wound over the temporo-sphenoidal lobe had entirely healed up.

Criticising this case in the light afforded by the *post-mortem* examination, we are able to follow the train of events which led to the fatal issue, and, at the same time, can form a fair conclusion concerning the most suitable treatment.

We see that a chronic inflammatory disease, apparently

originating in the tympanic cavity, had caused a carious process to be set up in a localised part of the surrounding bone, effecting thereby a communication with the extra-dural space<sup>1</sup> situated over the upper surface of the petrous bone.

This having taken place, the pus, in time, found an exit, and having, we may presume, collected to a certain extent at this spot, gravitated towards the *sulcus lateralis* on account of the normal incline downwards and backwards of the upper surface of the bone.

Having once reached this situation it found a convenient resting place for itself, and, at the same time, set up an inflammation of the coats of the adjacent sinus, which probably soon exerted its injurious effects upon the blood contained within.

It was at about this stage that the case came under treatment. The almost hourly fluctuations of the temperature were an index of the extent to which the blood was being poisoned by the absorption of the accumulated septic products, and the pain, optic neuritis, and frequent pulse denoted the meningitic irritation. The mastoid was now opened, and the release of the pent up pus, together with the depletion of the vascular turgescence, effected by the loss of blood during the operation resulted in a temporary amelioration of the symptoms. The most important seat of the disease, however, remained untouched, and, therefore, further complications ensued; the sudden appearance of rigors probably betokening the occurrence of secondary septic inflammation in other regions and development of a pyæmic state.

Such symptoms, then, as those detailed, met with in connection with purulent middle ear disease, are almost pathognomonic of implication of the lateral sinus and subsequent pyæmia; and, at the present time, the plan of treatment most likely to save the patient is recognised to be much as follows.

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<sup>1</sup> I am here, of course, not alluding to any *actual* space between the dura and bone at this spot, but only to a *potential* one, which, to be brought into existence, needs but the separation of the two structures by the force of extravasated blood, accumulated pus, or other agencies.

The mastoid antrum should be opened, and its contents, together with those of the middle ear, thoroughly cleared out. By enlarging the incision backwards, and removing the bone over the sinus, the pus accumulated around the venous channel can likewise be removed. The internal jugular vein should now be ligatured in the neck (the operation being most conveniently done at about the same level as that for ligature of the common carotid above the omo-hyoid muscle), the vein being divided between two ligatures. The lateral sinus should now be incised, and the contained clot removed, care being taken to deal with any extension of the clot backwards towards the torcular. This being done, the proximal end of the divided vein may be opened, and a stream of fluid made to run through from the opening in the sinus to that in the vein; and, finally, the skin wound in the neck closed, the opened upper end of the vein being stitched to the skin.

By this means we close the main channel by which the septic matter enters the circulation, and at the same time remove the focus of infection itself.

We can now pass on to consider some other complications, namely—

### III.—CEREBRAL AND CEREBELLAR ABSCESES.

Such abscesses may occur in two forms: 1, as scattered foci of suppuration within the cerebral or cerebellar substance; 2, as a single localised and well-defined collection of pus.

The former variety is, unfortunately, scarcely amenable to operative treatment, and is, necessarily, almost without exception, fatal. The latter kind is the only one which we can hope to treat with any measure of success: and here the brilliant results often obtained go far to compensate for the failures in the treatment of the former variety, which is the less common of the two.

It is beyond the scope of this paper to go into the details of the clinical manifestations of these complications; for the diagnosis of which the most intimate knowledge of the

functions and localisation of the various parts of the central nervous system is necessary.

It should, however, be mentioned that these encephalic abscesses may be present for a considerable time without exciting definite symptoms; and that unless we are constantly on the *qui vive* and ready for emergencies, their existence may be entirely overlooked. It is as well to recognize the possibility of their presence in all cases in which ill-defined nervous symptoms appear in the course of purulent inflammation of the middle ear, and to search carefully for further signs which may corroborate or refute such a supposition.

I will therefore do no more than give a brief report of two cases which lately occurred in the hospital, the one under Dr. Clarke's care, and by whose permission I am able to make use of the notes; the other under my own treatment.

CASE IX.—Marion Y—, aged 20 years, was first seen on January 28, 1890, during the first appearance of the "grippe" epidemic. She was complaining of general pains in the head, back, and limbs, and general malaise. The patient had never had any illness which was serious enough to make her lie up. A polypus had been removed from the right ear two years ago, and the ear had received some treatment since on account of the discharge. The family history was exceptionally good. The present illness came on seven days before first being seen, with feverishness, pains in the head and limbs. She had also been troubled with coldness of the extremities, and there had been some difficulty in passing water. The patient believed she had influenza, as several in the house from which she came were prostrated with it.

Examination of heart and lungs gave a negative result. The tongue was dry, slightly furred, and tremulous, and the breath was offensive. Temperature 102.2°. Three patches of herpetic eruption were present on the left side of the face; one being just below malar bone (temporo-malar branch of fifth nerve), another below angle of the mouth (buccal branch), and one on the chin (mental branch of infra-dental); there was, further, another patch on the right side of mid-line of

upper lip (infra-orbital branch). These patches had all appeared two days previously. The patient's mental condition was somewhat peculiar, constantly sighing and calling out with the pain in various parts of the body.

For the first two days in hospital the temperature ranged between 98° and 102°. There was very little sleep at nights, and the patient was often restless and talking at times incoherently. Retention of urine necessitated the use of the catheter.

On January 31, the following note was made:—"Temperature 99.2° last night, normal this morning. Catheter still used, 3xxx. of urine being withdrawn in last twelve hours. Sordes on teeth and lips, tongue still furred and herpes present. Pains in the limbs nearly gone, but complains of pain at back of head and neck. Is very dull when spoken to. Enema of soap and water ordered, as the bowels have not acted since admission. The enema was given at 11.15 a.m., and a few minutes after its administration the patient suddenly became comatose with stertorous breathing, insensibility of conjunctivæ, and widely dilated pupils. Death occurred in about three-quarters of an hour, the heart continuing to beat for two minutes after apparent cessation of respiration."

*Post-mortem examination* revealed slight congestion at both bases of lungs. Heart and spleen normal. Both kidneys somewhat congested, and capsule when torn off, carrying some of kidney substance with it. Liver contained more blood than natural.

Examination of brain showed marked fulness of the meningeal veins. On removing it from the skull the right temporo-sphenoidal lobe ruptured and about 3iii. of fœtid greenish pus escaped from the rent. A large abscess cavity was found occupying the greater part of the lobe, and lined with a thick pyogenic membrane (*v.* fig. 7). The roof of the tympanum upon which this part of the brain rested was discoloured and signs of caries of the bone were evident.

The usual symptoms of intra-cranial abscess, to wit, slow and sluggish cerebration; an abnormally infrequent pulse;

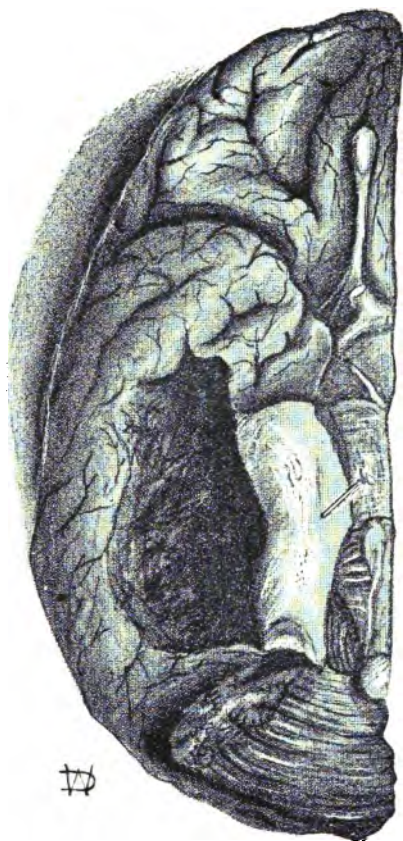


FIG. VII.—One half of the brain in Case IX., showing the abscess cavity which existed in the right temporal lobe.





constipation ; and, after an initial rise, the maintenance of a normal or subnormal temperature ; together with the cardinal signs of a coarse intra-cranial lesion, viz., vomiting, cephalalgia, and optic neuritis, were, in this case, masked by the effects of the attack of influenza from which the patient was evidently suffering. And when we add to this the fact that no mention of the previous aural condition was made by the patient herself, but only by her friends after her death, there is not much wonder that the cerebral complication was overlooked.

Our last case, though somewhat different in nature from the foregoing, is equally as interesting, and runs as follows :—

CASE X.—Matilda D., aged 34 years, suffering from mastoid caries, had been under Dr. Roberson Day's care for some time, and he sent her to me towards the end of January, 1893, with the following history :

A discharge from the left ear had been present ever since childhood. In January, 1892, she was suddenly taken ill with vomiting, pain in the ear and general malaise ; and within a few days a larger swelling appeared behind the ear. This was incised fourteen days after onset of illness and much pus escaped, without, however, giving much relief to the pain, which has really, with but few intermissions, continued up to the present time. The abscess healed up in May but "broke" again in two months, and the discharge from the ear became offensive. Towards the end of 1892 the sinus in the mastoid region was scraped and some carious bone removed, but there was not much improvement.

The patient continued to attend as out-patient at the hospital under me until February 22, when she was admitted to the ward on account of an increase of the pain in the head and other symptoms. On admission the temperature was 103.8°. She was complaining of severe pain in the frontal region, but no earache, and great bodily and nervous exhaustion. There was a small sinus in mastoid region through which a probe could be passed into the middle ear. In the external meatus was a mass of granulations arising from the posterior wall and evidently sprung from the bone, for the probe

could be made to pass through the sinus in the mastoid through them into the meatus. There was some tenderness to pressure over the course of the left internal jugular vein.

During the first four days after admission her general state did not alter much. The pulse maintained an average of 68 per minute, the temperature an average of 102.60. The pain continued, nausea occurred, and some deafness in the right (hitherto sound) ear was noticed; there was also a good deal of pain in the abdomen and thighs. No optic neuritis was observed. She was ordered *belladonna* and a weak iodine lotion to be syringed into the ear.

It being evident that the patient was not improving and that her state was serious, it was decided to enlarge the already existing opening into the mastoid antrum, and remove as much carious bone and diseased tissue as was possible, and at the same time examine the condition of the lateral sinus. Accordingly, on the fifth day after admission (February 27) an incision was made over the mastoid, with the sinus in the bone as its centre, and the ear was reflected forwards, the bone over the mastoid antrum chiselled away, and the cavity freely exposed and cleared out. At the same time the bone behind this was removed, a part of it being necrosed; and by this means the lateral sinus, which, from preceding inflammation, was shrunken to the size of a thin cord and completely empty, was laid bare. No collection of pus was found in the sulcus lateralis.

For three days following the operation the symptoms were markedly less in severity, though the temperature remained high, and pulse increased in frequency. The abdominal pain was also severe, and vision became blurred and occasional strabismus occurred. On March 6 the frontal pain returned in its former intensity, and the patient vomited four times without any preceding nausea. Constipation had been present all the time. The discharge from the ear and mastoid opening, though small in amount, was foetid. For the next two days the vomiting continued, the patient also complained of giddiness, and, at night time, muttering delirium was present. On

March 9 the state was critical, the patient being in a semi-conscious condition, groaning when roused and not answering questions. The eyes were turned upwards and outwards, and urine and stools passed involuntarily.

It was now decided to explore the brain for abscess. Under anæsthesia an incision was made down to the bone, one inch behind and above the external meatus, and a ring of bone removed by the trephine. Aspiration in all directions of the temporo-sphenoidal lobe thus exposed gave a negative result; and so a second opening was made, below and behind the opening of the lateral sinus, and the cerebellum explored, but no abscess was found. The lateral sinus was opened, but its cavity, which was so small that a fine probe could only be passed into it, was quite free of any thrombus. Finally, the mastoid antrum and middle ear were, for a second time, curetted and thoroughly washed out. The skin over the cerebral and cerebellar openings was closed by sutures. The patient made a good recovery from the operation, and was conscious and decidedly improved by the evening, and the improvement lasted for two days; food being taken by the mouth, and questions being answered clearly, but the involuntary passage of stools continued. Three days later the stupor re-appeared; involuntary twitching of right arm and leg occurred; and difficulty in swallowing, probably owing to paralysis of the pharyngeal muscles, was also noticed.

It was found that there was some tension in the wound over the cerebellum, and so the sutures were removed and some pus escaped. The opening was washed out, a drain inserted, and the discharge of pus continued until death two days later; the patient being in a comatose condition with stertorous breathing for about twenty-four hours prior to the fatal termination.

The chief remedies used were *china*, *hyoscyamus*, *lycopodium*, *merc. sol.*, *aconite*, *sulphur*, *glonoin*, and *merc. corr.*

Permission to make a thorough *post-mortem* was not obtained, but the cranial cavity was opened and the brain taken out for examination.

The cerebrum was found to be free from any collection of pus. In the cerebellum, three small abscesses were present; one, which was situated on the surface of the left flocculus, had ruptured, and its contents had been extravasated beneath the dura, in the meshes of the pia mater, over the surface of that lobe, and the left anterior column of the spinal cord, as low as the origin of the spinal accessory nerve, and as high as the lower border of the pons. The other two collections of pus were situated more deeply in the substance of the cerebellum, but close to the inner border, and were each

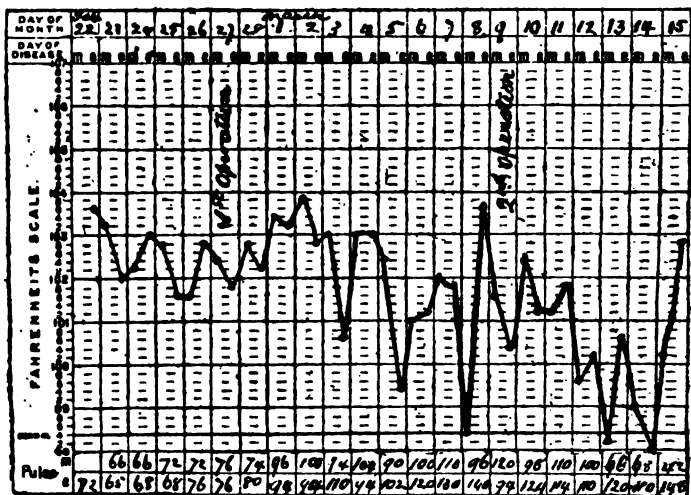


CHART II.

Case of abscess in the cerebellum with secondary spinal meningitis (Case X.).

about the size of a pea. It was found that the exploring needle must have penetrated the cerebellar substance to within about a quarter of an inch of the last two abscesses.

It remains now but to mention the last of the complications of middle ear disease, namely—

#### IV.—PURULENT MENINGITIS.

This may occur as the consequence of the rupture of a superficial abscess such as we have just been considering; or

it may arise from the occurrence of a direct communication between the middle ear and the meninges; and it may be localised or diffuse in its nature. If it be diffuse, we can scarcely hope for any success from operative interference; and should it be localised, its amenability to surgical treatment depends entirely upon its locality. If situated anywhere about the base of the brain, its position is inaccessible; but occasionally alocalised meningitis has occurred around the fissures of Sylvius and Rolando, and caused symptoms referable to irritation of the centres which lie around these two sulci, and it is encouraging to know that a few cases of this nature have been operated on with complete success by trephining and removing the collection of pus.

*Post-Scriptum.*— Since writing the above, I have had occasion to operate on another case of septic thrombosis of the lateral sinus and internal jugular vein with complete success so far as the intra-cranial complication is concerned.

The subject was a child aged 11 years, a patient of Dr. Moir, and had suffered from a purulent discharge from the left ear for two years. A few days previous to coming under treatment, she was attacked with severe pain in the region of the ear, with swelling in the neck below the mastoid process; but there was *no redness or swelling of the mastoid itself*, though marked tenderness to pressure, especially at its tip, was present. There was also high fever and slight double optic neuritis. The mastoid antrum was first opened and its cavity cleansed of a quantity of foetid pus. The following morning a rigor occurred, the temperature reaching 105.6° F. Thereupon it was deemed expedient to explore the lateral sinus, which was found surrounded by pus, and a hypodermic needle failed to withdraw blood from the sinus itself.

The internal jugular was then exposed in the neck and found to contain clot as low down as the entrance of the middle thyroid veins. A double ligature was placed round the vessel below the thrombus, and the vein divided. The lower end of the upper portion of the vein was then opened and stitched to the skin wound, and the clot removed. The

lateral sinus was also opened and its contents, which consisted of semi-purulent thrombus, likewise removed both from its upper and lower portions. Free hæmorrhage took place, but was easily controlled with a plug of iodoform gauze. The child did well after the operation, until the third day when she developed pneumonia at the left base which spread considerably. The head and neck wounds have, however, done uniformly well, and rapidly assumed a healthy condition, and the child ultimately made a complete recovery.

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## STUDIES IN GYNÆCOLOGY.

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### I.—THE INFLUENCE OF CIVILISATION ON THE REPRODUCTIVE LIFE IN WOMEN.

**Scope of the Enquiry.** NOT the least of Darwin's rich gifts to the intellectual life of the century has been the suggestive parallelism he indicated between the salient features of the life of the individual and the life of the race. Our study primarily concerns itself with a special development of this parallelism in the effects of civilisation upon the reproductive life. Narrowing our sphere of review we propose to examine in detail the baneful influence of latter-day civilisation upon the feminine reproductive functions. A critical consideration will clearly show that these detrimental effects are not essential products of every scheme of civilised life, but are rather due to the ill-balanced and one-sided methods of the present form. Pursuing our former parallelism we shall show that the prophylaxis of nature for the easy and adequate transmission of the best qualities of the race is that which is to be imitated in a similar endeavour in the history of the individual. Finally, that the remedial measures adopted by nature for the restoration of vigour to a race suffering from declension, are the best models when a similar problem exists in a few generations of individuals.

#### THE SIMILARITY OF LAWS OF DEVELOPMENT IN THE RACE AND IN THE INDIVIDUAL.

**Their Incidence on the Race.** Few intellectual pursuits are more interesting, or tend more vividly to indicate how the laws of progress are unified, than to compare the operation

of these in the life of the nation and in that of the individual. The formative period in a nation's life, the transitional time from the irregular activities of nascency to the compact unity of a well-formed state, is a time when it is most responsive to the moulding of forces from without. Thus the ease and regularity with which food is procured ; the impetus of necessity in braving the rigours of climate and open sea ; the demand for constant activity and resourcefulness in maintenance and defence of life are conditions which form and fashion the type of national life, as well as determine its permanence.

In later years, the readiness with which new functions can be performed and new departures instituted ; the ease or the difficulty with which constant adjustments can be made to meet constantly altering conditions and tendencies ; the fortitude and resistance with which adverse influences are met, and the ease of recuperation, are justly taken as valid evidences of the vitality of the national life.

And when, after an emasculated existence in luxurious ease, when no longer has there been the imperious necessity to toil and spin ; when the enervated and asthenic race is scattered by the kindly hand of misfortune ; it is by recurrence to a simple and natural life that new vigour is gained, dormant energies revived, and the lax calibre of the body politic revived and toned.

These experiences are paralleled exactly in the life of the individual.

**Their Incidence on the Individual.** The course and character of the adult organism is largely determined by the physical conditions present in its adolescent stage. The plastic and receptive constitution now takes on the permanent imprint of the influences which mould it ; pure air, good food, healthy employment and absence of strain, determine the vigour and resistance of the body in maturer years. It is in adolescence that the use and wont of the constitution in later days is largely conditioned and determined.

When the preparatory stadium is over, and in the fulness of time the man measures himself against his work in the world,



it is the amplitude of his physical resource, the degree of his bodily fortitude, and the versatility of his corporeal faculty, that fortify him against the tierce and thrust of accident and disease. It is in the ready capacity to adjust his life to altered conditions ; to the ductility of his powers in meeting unexpected contingencies ; in the many-sidedness of his relation to encompassing influences that his progress and preferment are ensured.

And when, after stress and storm, the organism has been shattered, a place of salvation is still found for it, to enable it to return to the *status quo*. The recuperative power of the body, the tendency to recovery is most favoured by a return to natural simplicity in life and habits. That food is most salutary which, in the scale of nature, is most elementary ; that routine is most invigorating which ensures contact with the kindly elements ; that activity is most productive which is in due proportion to all the functions of mind and body. To recover health, we must again resume our touch with nature, again lead the original simple life, again recur to that natural environment which is always most favourable to growth.

**The Correspondence as a Criterion.** The analogy between the racial and the individual life is capable of still further development ; and the correspondence in the historical features of each demonstrates the same laws of progress, decadence, and recovery in both. Thus the history of the one mirrors, as well as complements, the history of the other ; by the light of their results in the history of the race we can estimate the working of any habits or modes of life in the individual of to-day : and the importance of the racial test as a criterion of individual habit or character is thus demonstrable.

#### THE RELATIVE PERMANENCE OF ALTERNATIVE MODES OF AGGREGATE LIFE.

**Rural and Urban Life.** From the earliest times the history of mankind has been the history of recurring and varied experiments in manner of life. These experiments

narrowed themselves, in process of time, to two alternative systems; the rural and the urban. The later history of mankind records the recurring supremacy of the one or the other method. In the nomadic-rural type we see the simplest and most elementary manifestation of the social organism. Moved by an inherent impulse, the natural tendency of mankind has always been to leave the simple life, and to construct the complex; and by artificial measures, to modify the struggle for existence, or to nullify the survival of the fittest. Invariably as time wore on, the instability of the urban-civilised plan of life has been proved; and history has furnished us with the records of a round dozen of civilisations, for whom decadence has been the common lot.

**Inherent Defects of Urban Life.** In the past history of the world we thus read clearly that civilisations hitherto have carried within them the elements of their own destruction. Since the early days of man numerous civilised states have arisen, and each and all have eventuated in the decline of the peoples who developed them. There is no more pessimistic page in the world's archives than the unvarying record of the physical decadence of civilised mankind. On the other hand, pastoral peoples, whose lives are more natural, have in some instances maintained the integrity of their national existence down to the present day. Every detachment of man from the natural surroundings in which the race was cradled, every endeavour to substitute the easy life of a dweller in towns for the healthier routine of rural events, has failed by reason of an ill-compensated scheme of civilised life.

#### THE REPRODUCTIVE SYSTEM AS THE INDEX OF DETRIMENT IN ANY FORM OF CORPORATE LIFE.

**General Effects of Unhealthy Life on Reproductive Functions.** The reproductive system is the conduit through and upon which the deteriorating influences of civilised life are manifested. The natural law of the survival of the fittest, through natural selection, is suspended, and no equivalent

system of check and countercheck takes its place. The sick, the halt, the lame and the blind are allowed to perpetuate their defects in the ensuing generation without let or hindrance. All the detrimental influences of urban life, the unhealthy occupations, the overcrowding, are gathered and perpetuated in the stream of heredity which is the chief factor in racial continuity. Like variations in a state of nature, unprofitable changes in civilised life become inbred; however multiple the cause, the effect, the physical deterioration of the progeny, is constant, and the test of the value or disservice of conditions of life is the character of physique shown by the ensuing generation.

**Specific Effects on Reproductive Functions.** But more than this, much more than this, is the quite especial and selective effect that altered conditions have upon the reproductive functions. Again and again Darwin<sup>1</sup> insists on the peculiar sensitiveness which the processes specialised for procreation show for unnatural conditions of life. As the numbers in a community increase, the struggle for existence becomes more keen; the increased stress of life acts primarily as a disturbing agency on the reproductive system, and there ensues a difficult, painful or exhausting performance of the appropriate functions. Every defective element then in a civilisation strikes directly at the perpetuation of the race; however protean the disturbing cause, the primary effect is always a jarring of the naturally harmonious chords of the generative rhythm. The importance of this law it is impossible to over-estimate; that all non-natural influences in civilisation must primarily be expressed in terms of deviation from the normal in the functions of the reproductive life. And conversely, the value and permanence of any routine of existence is to be tested by the ease and naturalness with which the elements of the generative cycle are rendered.

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<sup>1</sup> "Origin of Species," pp. 5, 7, 106, &c.

### ACTUAL PERNICIOUS EFFECTS OF CIVILISATION UPON THE REPRODUCTIVE LIFE.

How detrimental our ill-compensated civilisation has actually been to the reproductive life in women is evident from the following considerations :—

**On Fecundity.** The reproductive power has increased with civilised races, and the families of non-civilised peoples are usually small. The inherent tendency of the life of civilisation is to stimulate the reproductive function, with no compensatory faculty to obviate its debilitatory effect on the feminine organism. Briefly, civilisation increases the reproductive function and lessens the natural forces for its safe conduct. "All our domesticated quadrupeds and birds . . . . are more fertile than the corresponding species in a state of nature. . . . We might expect, therefore, that civilised men would be more prolific than uncivilised. It is also probable that the increased fertility of civilised nations would become an inherited character."<sup>1</sup>

**On the Process of Parturition.** That the civilised organism is more exhausted than the non-civilised by the parturient process is obvious and demonstrable. In the natural state this function is but one among many; in the artificial conditions of modern life it is the paramount and predominant event during the years of fertility.

A few years' consecutive exercise of this function usually suffices to exhaust the nervous mechanism governing its recuperation. We are told that an American Indian woman, on the march with the tribe, would fall out as the hour of parturition approached, endure the throes of childbirth, and rejoin the tribe ere the day was over. Lubbock and other authorities narrate with point, how in the Pacific Islands, the mother, immediately after parturition, actively engages in domestic duties; while the father is put to bed, and nursed with the care more properly devoted to the other parent. In rural districts, cases

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<sup>1</sup> Darwin, "Descent of Man," p. 45.

of this natural vigour are observed from time to time. I have received, on excellent professional authority, the account of a Scotch woman, whose parturition occurred at a particularly busy juncture in farming interests. She was actively engaged in the field until the last, safely brought forth her child, and rose and went about her work the following day almost as though no parturition had occurred. As a rule, the more urban the life, the less is the power, of easy parturition and easy recuperation. The resources of civilisation require the forceps to be applied on the average in twenty per cent. of deliveries. The devastating mortality in thickly peopled centres from puerperal fever resulted in the immortal discovery of Semmelweis, of the value of antiseptics in parturition. And the increasing difficulty of lactation as supplying to the infant the natural "nahrungsmittel," is of the experience of all of us. These are some of the penalties the refined and educated married lady pays for her civilisation.

**On the  
Susceptibility of  
the Reproductive  
Organs.**

Manifold are the facts which demonstrate the increased susceptibility of the reproductive organs to external changes and nosological influences. The Anglo-Saxon race has been nurtured amid a certain rigour of climate and sudden variation of temperature, which are, indeed, normal to the environment. In the rural districts, from whence the finer types of population are recruited, there exists a healthy tolerance of climatic changes and temperature variations. Quite different is the enfeebled resistance of the organism whose vigour has been impaired by the valetudinarianism of civilisation. A moderate chill or wetting, especially during the period, often eventuates in a pelvic storm which leaves the permanent imprint of its path in catarrhal tubes and adherent ovaries, with constant and wearing pain. Even the transition from residence in a house with wooden to one with stone staircases has been known to cause a suspension of the menstrual function. And the present generation beholds the unedifying spectacle of young girls hardly out of their teens requiring treatment for painful uterine displacements, or still

more painful dysmenial troubles, or copious and debilitating leucorrhœa, or pelvic pain from defective nutrition of the reproductive organs, or irregular and excessive metrorrhagia. The lineal ancestress of any one of these cases two centuries ago would behold with scorn a handmaiden who required to absent herself from duties at such period, or who was the victim of a mysterious trouble calling for constant rest, or whose capacity for physical exercise was only a very limited quantity. And, farther back in historical sequence, the maternal stock of our Scandinavian progenitors braved the rigours of chill and damp, endured forced marches, underwent prolonged privations, shared the risks of martial life, and withal peopled the land with hardy warriors, whose inherited physique enabled them to make an epoch in history.

**By Increasing Tumour Growth.** Nature and man but rarely present us concurrently with two sections of a race, the one living a perfectly natural and uncivilised life, the other with the effects of a century of the habits and restraints of civilisation. Such a comparative study in anthropology we find to-day in the negro race. The unsophisticated lives of the uncivilised negresses have no stimulus and no tendency to the production of uterine fibroids, while among the feminine portion of the same race, transplanted to the United States, fibroma uteri becomes in a few generations a veritable scourge.<sup>1</sup> We have further learned from the graphic narrative of Marion Sims that his prime inducement to gynæcological work was the frequency of vesico-vaginal fistulæ in the negro women in his locality. The altered proportions of the parturient forces had already engendered this result, whose frequency of occurrence far exceeded anything noted in the condition of the women anterior to transplantation.

**By favouring the Occurrence of Dysmenia.** Within the present century painful menstruation has advanced from the torment of a remnant to the affliction of almost the majority. It is usual to find mothers, so total and entire

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<sup>1</sup> Lawson Tait, "Diseases of Women," p. 188.

strangers to menstrual pangs as to scout the all too real sufferings of their daughters as naught but whims and morbid fancies. We have no exact statistical record of the ratio of dysmenia in earlier times, but we do know that never before has it assumed such predominance in the sufferings of women; that its increase is proportionate to and simultaneous with the shifting of the conditions of life from country to town; that the most frequent factor in its induction is the type of organism common under artificial, and infrequent under simple conditions of life; and that its evolution in a given case may be watched, from its absence in a rural and healthy environment, to its inception and full display as the venue changes to urban life and duties. Clear and cogent are the conclusions to be drawn from a survey of the ease or the difficulty of menstruation under varying conditions. Low in the scale of civilisation, it is, so far as we can learn, inconspicuous and painless.<sup>1</sup> So also is it in present day instances when the environment is healthy, the food simple yet sufficient, and the years of juvenescence largely devoted to physical pursuits. But as the amount of deviation from the balanced conditions of a natural life, so is the difficulty and pain in the co-ordination of the new reproductive functions at puberty; whilst

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<sup>1</sup> When during the past year a tribe of women but one degree from barbarism were brought to London, an eminent specialist of scientific attainments spent some hours in investigation, through an interpreter, into the various phenomena of the reproductive life when non-corrupted by civilisation, though the enquiry was fraught with much difficulty, many interesting facts were elicited. It was found that menstruation was periodic, was inconsiderable, while in no way could the conception of accompanying pain be grasped by them. It did not enter into their category of facts—it was not laid stress upon, it was not even alluded to, by the respondents. The same investigator also ascertained, through the literary representative in this country of Emin Pasha, that in the records of personal observation by the renowned traveller, there were no indications that menstruation was a fact of any importance in feminine non-civilised life; or even a notable element, much less a painful incident. Emin was a medical man, and had close and personal association with non-civilised people leading a natural life.

in the simpler structure of a thoroughly rural life, the procreative processes are almost unconsciously added to the other functions of the organism.

**By the Increase of Uterine Deviations.** But the chief latter-day insistence of the general problem of aberrations from the normal reproductive cycle is seen in the study of uterine deviations and their sequelæ. In no other organ at the present time, is the *restitutio in integrum* after physiological activity so hampered by chronic changes in shape and site. Uterine deviations were observed in the days of Hippocrates; and down so late as the sixth century, they were described in medical writings. Not until the eighteenth century do they seem again to be of sufficient importance to occasion special consideration. So many feminine organisms are easily rendered *hors de combat* by influences which, in earlier times, or in rural conditions, are among the unnoticed experiences of daily life. Were the suffering from uterine displacement nearly so acute in a natural as in an artificial mode of life, the routine of the former would be impracticable, and every country woman a martyr to the incidents of existence. The later importance of uterine deviations is strictly relative, not to their mere occurrence, but to the associated conditions of pelvic congestion, atonic muscular fibre, and limp ligaments, which cause and accentuate the deviation itself. It is superfluous to demonstrate the peculiar fitness of a present-day environment for the origin and perpetuation of such unhealthy conditions. Equally superfluous is it to detail the protective mechanism of a natural existence, by which untoward influences are obviated or eliminated.

**By Suppressing Normal Conception.** More disastrous than any other civilised "necessity," is the reckless use of means calculated to lessen or neutralise the normal fertility of the married state. A well-defined group of nervous phenomena often accrue, so characteristic that the expert can detect and isolate them with considerable accuracy. It is impossible to tabulate statistics of these means and



results; but chronic pelvic congestions, relapsing pelvic peritonitis, or permanent sterility, over and above the complex of acute nervous symptoms, are commonly observed as the direct pathological results of such physiological malpractice. The women of the more civilised nations resent the burden of maternity with unnatural dislike: both in the Old and New Worlds the natural sequence is arrested and disturbed with increasing frequency; and a large share of pelvic lesions is daily added to the work of the specialist, the direct outcome of physiological unrighteousness. A careful study of the polity of the Jewish nation as regards the reproductive life of the married state, might contribute to the alteration of procedures which threaten extinction to Gentile races.

**By Causing  
Various Lesions  
of Puberty.**

I have elsewhere dealt with the tropho-neuroses of puberty. In these "we have some form of trophic neurosis of a new type, because conditioned by a latter-day set of influences. We have, as a prime element, a type of constitution styled by Niemeyer 'vulnerable.' Upon this organism, whose resources hitherto have been fairly equal to the demands of juvenility, comes the stress and strain of puberty; and the halting, irregular, and painful performance of the new function sufficiently attests the difficulty of its co-ordination by the bodily powers. This is the first serious crisis in the course of development, a crisis which comes at a time when, forsooth, the moderate energies of the budding girl are absorbed by the intellectual cramming of the high school; or depressed by a defective regimen, or an increasing limitation of out-door life." Here we see the latest development of the inflictions of civilisation on the feminine reproductive life; for now we see not perverted functions after establishment, but the break-down of an organism at their attempted initiation.

### THE DETRIMENTAL RESULTS OF CIVILISATION ARE AVOIDABLE RESULTS.

Is it then a necessary and inherent tendency of the civilised life to undermine the forces that regulate the reproduction of the species? Assuredly not.

The essence of civilisation is a redistribution of the system of nature for the maintenance and welfare of mankind. For nature's ways are crude, and can be developed; her processes are wasteful, and can be economised; her operations are simple and are more productive when combined. But the main relations of nature to man must ever remain undisturbed; this is the *sine qua non* of permanence in civilisation.

**The Peculiar**      The leading and distinguishing feature in  
**Integer of Civil-** our civilisation is the recognition of the par-  
**sation.**              amount claims of the individual as against  
those of the race. Nature, we are told, is "careless of the single life" and "careful of the type." Man, on the other hand, is "careful of the single life," preserving all individual existences, and offering no bar to their free appearance, no matter how defective the heredity, how unhealthy the parentage. This is the crux of all forms of civilisation, and every type hitherto has fallen and been swept away, because of this uncompensated cancelling of nature's checks. The weak, the halt, the lame, the blind, are, by the brute forces of nature, or the no less brutal passions of man, in an uncivilised community, exterminated. It is the glory of civilisation that these weak units shall be fostered and nurtured into the maximum of health and comfort attainable. Here purblind civilisation ends. Pre-occupied with our duty to the individual, we have forgotten our obligation to the race. How best shall we prevent the generation of the unhealthy units of mankind? With what speed ought we not to act upon the danger signal of detected hereditary disease, to prevent its perpetuation? The effect of this re-modelling of the order of nature upon the balance of the reproductive scheme is two-fold. Directly, the healthy harmony of the generative cycle is exactly as the

degree of robustness and tone in the adult. Indirectly, and more importantly, the reproductive system has a quite unique response to every varying or novel phase of life. The most sensitive index of deviation from a natural advance in life, is manifested by the corresponding functional alterations in the reproductive rhythm. The regularity or the converse of the latter is thus an unfailing test of the naturalness or the artificiality of the mode of living.

**The First  
Inherent Defect  
of Modern  
Civilisation.**

This, then, is the first fatal defect of civilisation as we know it, the uncompensated abrogation of nature's checks upon the perpetuation of a debilitated physique, or of an actual morbid taint. A more enlightened philanthropy and a sounder civilisation will obviate this error, by the well-guarded limitation of the reproduction of the species, as well as by the concurrent removal or repression of every influence and tendency which make for physical and, therefore, reproductive debilitation. It is not beyond the wit of man to devise a perfectly feasible plan, which shall be the civilised equivalent for the crude process of natural selection.

**The Second  
Defect.**

Next in detrimental tendency in the scheme of civilisation is the massing and aggregation of human life in large towns covering relatively small areas. If the history of civilisation be of any value or suggestiveness, if one fatal stream of tendency more than another be obvious, it is the uncontrolled centralisation of national life at the expense of a natural rural environment. The suicidal character of this policy has been equally patent to sanitarian,<sup>1</sup> scientist,<sup>2</sup> and social reformer.<sup>3</sup> And again, the best test of its hurtfulness is afforded by the phenonema of the reproductive functions working in such an environment. Each and all of the difficulties, abnor-

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<sup>1</sup> B. W. Richardson : "Hygeia : A City of Health."

<sup>2</sup> Baron v. Liebig : "Letters on Chemistry."

<sup>3</sup> William Morris, "Earthly Paradise," &c.

malities, and defects in the reproductive cycle before dwell upon act most strenuously under conditions of city life. It is in towns that puerperal septicæmia is at its worst. It is in towns that puerperia are tardy and delayed, that lactation earliest fails, that child-bearing soonest exhausts the maternal procreative power. It is in town life that the embarrassment of dysmenia, the trophoneuroses of puberty, the ready vulnerability in general of the generative system, are easiest and soonest manifested. It is possible that civilisation might overcome the disintegrating tendency of the generation of the unfit, if the environment were rural. It is certain that present-day civilisation will not withstand the ceaseless sapping of the forces which regulate a healthy continuity, a normal reproduction of the race.

These criticisms of modern civilised life each thinker can expand and amplify for himself.

#### THE PROPHYLAXIS OF NATURAL LIFE AND OF CIVILISED LIFE FOR MAINTAINING THE INTEGRITY OF THE REPRODUCTIVE POWERS.

**Comparison of Methods.** The problem of nature in maintaining a progressive standard of vigour in the continuity of a race is solved by various automatic mechanisms, foremost among which is natural selection. The problem of civilised man in compassing the same end lies in the abrogation of natural selection, which is inhuman and indiscriminating, and in the substitution therefor of voluntary check and counter-check. Thus the prophylaxis of nature, because automatic, is constant and effective, and the prophylaxis of civilised man because arbitrary, is unstable and inadequate.

**The Essentials of a Civilised Method.** How shall we best frame our scheme of safeguards to preserve inviolate an efficient mechanism for the propagation of a healthy race? How can we best combine the adequacy of the plans of nature with the discrimination essential to man's?

We live under a *régime* of nature, with a certain redistribution in detail effected by civilisation. Our aim, therefore, in the re-arrangement of the conditions of life is to preserve the essential features of the *régime* intact, whilst effecting such a disposition of detail as is a befitting order for the cerebral development of man.

An ideal civilisation thus demands an entirely new sociology. We must substitute an active and intelligent co-operation with the laws of a healthy and progressive civilisation, for the partial acquiescence and partial defiance thereof, tinkered by an invertebrate philanthropy.

There requires some efficient control over the means for carrying on the perpetuation of the race, with a certified fitness of antecedents in each case. The best conception of the value of human life is but poorly realised by placing no bar upon its reckless or unwarrantable introduction, often crossed by the bar sinister of hereditary disease.

There requires a due and proportionate arrangement of the elements of the environment—the locality, the avocations, the habits of life—in women, to insure that easy and unexhausting discharge of the functions of reproduction which is the expression of a healthy mode of life. It cannot be too often repeated that the first effects of a non-natural existence are incident upon the reproductive system; that every defective or disproportionate element in any civilisation strikes directly at the perpetuation of the race, and that all non-natural influences are primarily expressed in terms of deviation from the normal in the functions of the reproductive life.

**The Difficulties of a Civilised Method.** The prophylaxis of nature for the maintenance of reproductive health in women is effected in two ways. First, by the provision of healthy and simple conditions of life. Second, by the gradual extermination of weak organisms whose recuperation is defective. The struggle for existence gradually sweeps these away. The prophylaxis of civilised man for the same end has as its prime element also the institution of healthy and simple conditions

of life. Concerning the second part, civilisation has a conscience ; it cannot exterminate weak lives, like nature. Its ideal method of dealing with defective vitalities is to tone the flagging powers and stimulate recuperation, while, at the same time, carefully neutralising the tendencies of the weak or diseased to transmit their defects. Thus the preventive measures of civilisation are more heavily taxed than those of nature ; for nature stamps out, civilisation levels up. Nature's methods are compulsory ; those of civilisation are optional. But the result of deviation from the essentials of any sound method for the maintenance of the calibre of the race is that the reproductive functions at once suffer, indirectly as well as specially, and out of obvious proportion to the disturbing cause.

#### REMEDIAL MEASURES.

##### **The Necessity for the Copy of Natural Prototypes.**

Our plan for the selection of remedial measures is clear. Relative to a purely natural environment the elements of the reproductive scheme were originally evolved. Under an entirely natural *régime*, the healthy standard of reproductive life is always maintained. We can construct a perfect scheme only by going back to natural models.

**The Success of  
Natural Methods.** The reproductive functions in a natural environment are easily performed, slight in their incidence, and followed by rapid recuperation. Moreover, this type of life ensures a flexibility, a capacity of accommodation to altering external conditions, which is the sure mark of a healthy constitution. Constant contact with nature, and constant reciprocity with nature alone have developed and maintained that type of organism in which the reproductive life is accompanied by the acme of physical vigour. It is essential that there be constant contact with nature ; for only thus are the essential attributes of robustness and health produced. It is essential that there be constant reciprocity with nature ; for all habits and routine otherwise

modelled are invariably detrimental, and, sooner or later, must be eliminated.

**The Racial and  
the Individual  
Remedy.**

When the health of a people is debilitated by civilised life ; or their natural recuperative powers sapped by effeminate customs, or their normal tendency to progress enthralled by luxurious indulgence ; then there is no hope of their rejuvenescence unless they recur to a simpler and rural method of living. When the organism at puberty is unable to co-ordinate the functions or endure the onset of the early reproductive life ; or, when in maturer years it is unable longer to withstand the slings and arrows of disease and debility, the remedy is also a recurrence to a simpler and more natural life and surroundings. "Back to the land" has a therapeutic as well as a political significance.

The gains of women from civilisation have been immense ; but a legion of concurrent evils has stealthily crept in whose noxious influence is cumulative. The race is preserved from tendencies to extinction only by the natural lives of the non-urban remnant, for it is perfectly and demonstrably true that every alteration in natural conditions of life touches soonest and most profoundly the reproductive system ; and the criterion of the healthy routine of a people is the harmony of the cycle of reproductive functions.

## **SLOW PULSE (BRADYCARDIA) WITH EPILEPTIFORM CONVULSIONS.**

By BYRES MOIR, M.D.

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CASES of slow pulse, that is, when the beat is below 40 per minute, are of rare occurrence, and are usually associated with irregular cardiac rhythm. A few instances have been reported where the pulse has been observed for a number of years, and always found to be regular, but below 40.

The case given below was under my observation for more than five years, and I was able to take frequent sphygmograms; these never showed any irregularity, nor was I ever able to detect such with the stethoscope. The average beats were 30 per minute, varying from 24 to 32, and only once during a febrile attack reaching 40.

The case is also of interest from the association of epileptiform seizures with the slow pulse, the first attack coming on at the age of 60:—

W., a short, stout-built man, had always enjoyed good health, was active and leading his usual life, when, in 1883, at the age of 60, he had a severe epileptic seizure. I saw him soon after the attack, and found that up to this he had thought himself quite well, and had never had to consult a doctor. The attack was a true epileptic one, of the major type; he fell to the ground unconscious. This was followed by general tonic and clonic spasms, with lividity of the face; the tongue was bitten; urine passed involuntarily, and he had no recollection himself of what had happened.

The urine was quite free from albumen. The pulse was full, strong, but slow—30 to the minute. The apex beat was diffuse, but both cardiac sounds were clear, and the heart



## SLOW PULSE WITH EPILEPTIFORM CONVULSIONS. 101

beats were quite regular and corresponded in time to the pulse. From this time up to his death, seven years later, he was subject to these attacks; he would sometimes have five or six, similar to the above, closely following one another, and then a year might elapse without one; and all this time he was able to go about as usual, and did not suffer from dyspnœa, though his pulse varied from 24 to 32; but I noticed the attacks were more likely to occur during very cold weather.

In 1886, he had a very large carbuncle on his back; his temperature rose to 101°, but the pulse was never above 40, and his weakness was so great that he frequently fainted while the carbuncle was being dressed. Soon after this the heart showed signs of fatty degeneration; it was hypertrophied, the apex beat being still diffuse; but outside the nipple line, and over the apex, a well-marked mitral systolic bruit could be heard.

He left London about two years before his death, and I did not see him again. His death was very sudden; he had been talking, and seemed apparently well, got up and walked out of the room, and was found a few minutes later dead in the passage. No *post-mortem* was made.

I took frequent tracings of his pulse with Dudgeon's sphygmograph, and give three specimens, taken at different times, the first one soon after his first attack; the first two with 2 oz. pressure, the last one with 4 oz.

The relation of slow pulse to epileptiform seizures is one of great interest. Kussmaul and Jenner,<sup>1</sup> in their essay on "Epileptiform Convulsions from Hæmorrhage," showed by their researches that (1) the convulsions appearing in profuse hæmorrhage of warm-blooded animals (including man) resemble those observed in epilepsy; (2) interruption of the circulation in the great arteries of the neck causes arterial anæmia of the brain, and this anæmia produces convulsions.

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<sup>1</sup> Kussmaul and Jenner, "Epileptiform Convulsions from Hæmorrhage," New Sydenham Society, vol. v.

Dr. Moxon<sup>1</sup> laid great stress upon the action of anæmia of the brain as a cause of epilepsy, and went so far as to suggest that the initial event in common epilepsy was a stoppage of the heart. Dr. Raymond Tripier<sup>2</sup> considered that the slow pulse with epilepsy was always associated with alterations of cardiac rhythm, and that it was an effect of epilepsy. Dr. Broadbent,<sup>3</sup> in his chapter on Infrequent Pulse, goes fully into the question of altered cardiac rhythm, and shows that in many cases of slow pulse there is a double heart beat, only one being felt at the wrist; but he does not accept Dr. Tripier's conclusion, and states: "I look upon convulsive attacks, when they occur in connection with an infrequent pulse, as a result of cerebral anæmia, produced exactly in the same way as convulsions after great hæmorrhage."

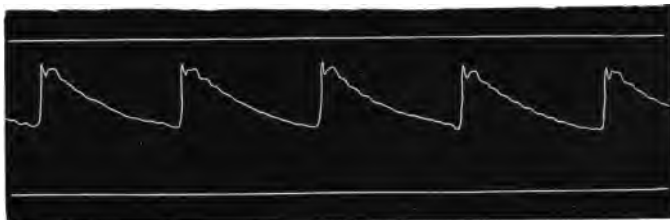
The case I have narrated seems fully to bear out this conclusion. I frequently listened to the heart with my hand on the pulse, and never detected any double beat; and it was not till the man had been under observation for some years that I made out any bruit. He had never suffered from any kind of fits till he was 60; no albumen was found in the urine at any time, and in this case the epileptiform attacks seemed to be due undoubtedly to cerebral anæmia.

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<sup>1</sup> Dr. Moxon, "Pulse in Epilepsy," *Lancet*, 1881, p. 846.

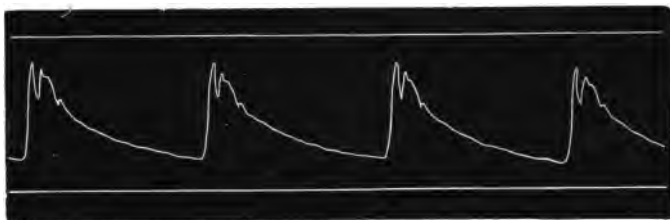
<sup>2</sup> Dr. R. Tripier, *Revue de Médecine*, 1883-1884.

<sup>3</sup> Dr. Broadbent, "The Pulse."



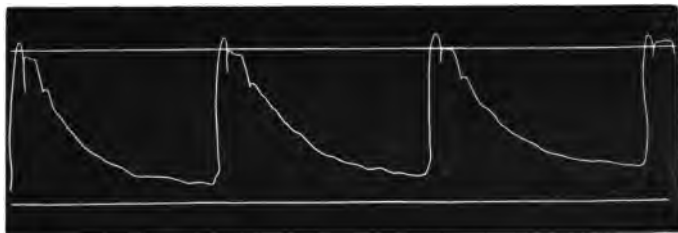
No. I.

2 oz. pressure.



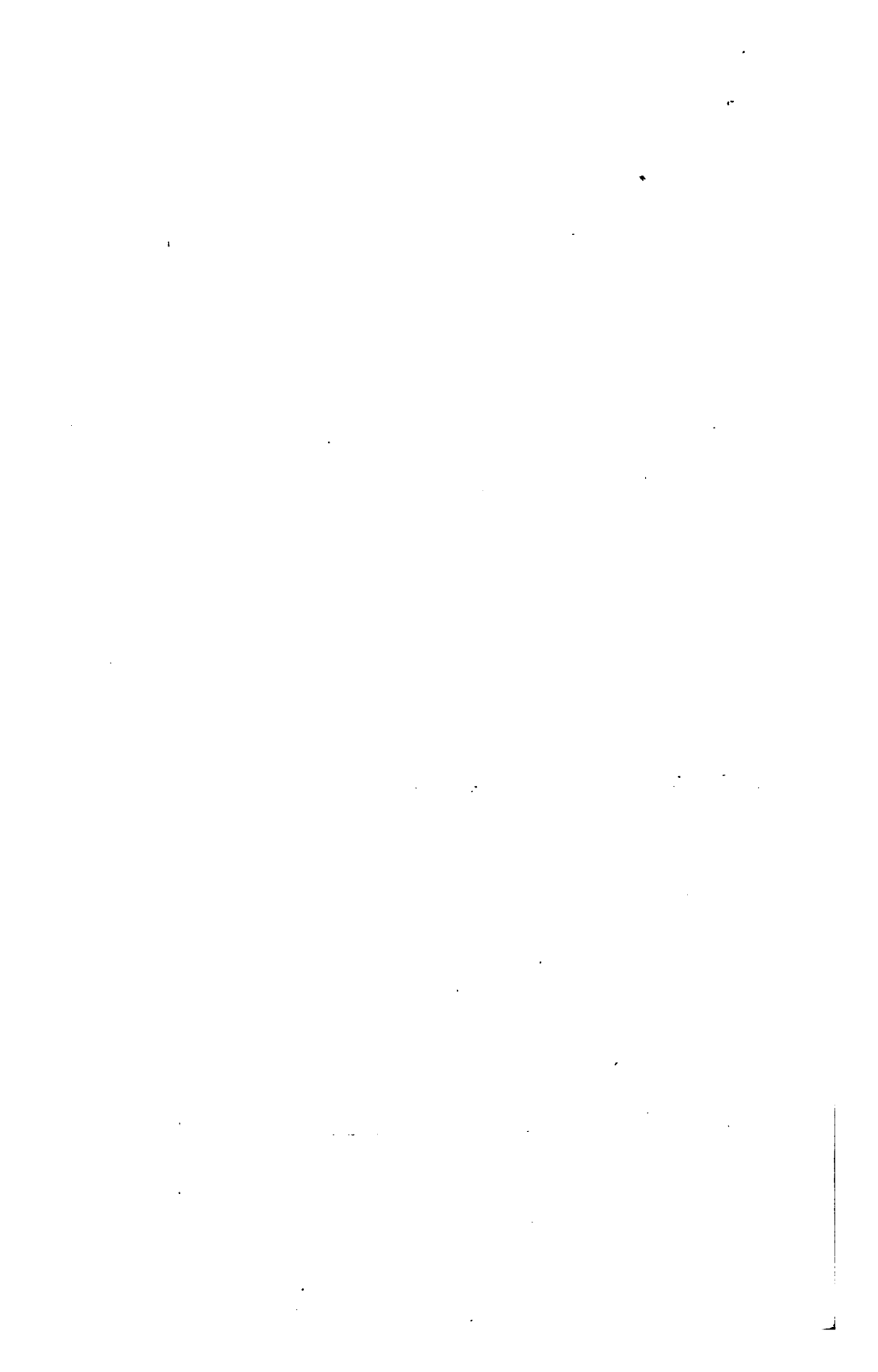
No. II.

2 oz. pressure.



No. III.

4 oz. pressure.



**A CASE OF TYPHOID FEVER WITH HYPERPYREXIA,  
TREATED DURING THE ACUTE STAGE BY HYDRO-  
THERAPY.**

BY WASHINGTON EPPS, L.R.C.P.

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THE following case is of especial interest for two reasons :  $\alpha$ , the extreme height to which the fever reached, namely,  $108^{\circ}\text{F.}$ , I think the highest ever noted in typhoid fever in this hospital in a patient who recovered ; and  $\beta$ , the apparently good effects of the cold water packs and cold water baths. I say "apparently" because cases of typhoid with extreme hyperpyrexia are so rare and exceptional that one is not able to compare the results obtained from homœopathic treatment with that obtained from cold applied in various ways. For this reason, also, one is unable to foresee what the termination of these hyperpyrexial cases would be, if treated entirely by drugs. After a most thorough search through the principal British homœopathic journals (*British Journal of Homœopathy*, *Monthly Homœopathic Review* and *Annals of the British Homœopathic Society*), I have found only two cases of typhoid fever in which the temperature reached over  $105.4^{\circ}$ , and which bear on this case.

The first is reported by Dr. J. Galley Blackley, in vol. x., page 132, of the *Annals of the British Homœopathic Society*, of a patient of 21 years, suffering from typhoid fever, complicated at the commencement with symptoms of acute inflammatory rheumatism, in which the characteristic typhoid spots appeared on the thirteenth day of the disease, and in which the axillary temperature was  $108^{\circ}$  just before death. As the symptoms in this case were very similar to those observed in

mine, when the temperature ran up to  $108^{\circ}$ , I will quote Dr. Blackley's note for the last evening and night in his case:—

"At 5 p.m. I saw the patient again and found her delirious, with brightly-flushed face and dilated pupils. Temperature  $105.2^{\circ}$ .  $\mathcal{R}$  sod. salicyl. gr. xx. every three hours. Early the following morning after a troubled night the breathing became embarrassed, and she died at 6 a.m. with a temperature in the axilla just before death of  $108^{\circ}$ ." At the autopsy the cerebrum and cerebral veins were found engorged, the lungs hypostatically congested and œdematous; the spleen slightly enlarged; the mesenteric glands enlarged, and Peyer's patches inflamed, swollen and pulpy.

The second case is reported by Dr. J. H. Clarke in vol. x., page 249, of the same Annals, of a patient aged 15 years; admitted with typhoid, complicated with broncho-pneumonia. The patient had been ill nine days before admission. She was unconscious when admitted, and remained so for ten days until she died on the nineteenth day of her illness, when the temperature at 3 p.m. rose to  $107.2^{\circ}$ . The patient died at 3.35 p.m., and at 4.15 p.m. the temperature was  $109.8^{\circ}$ . At the autopsy the following conditions were found:—Old adhesions in pleural and peritoneal cavities; small ulcers in the lower part of the ileum; the liver enlarged and pale in colour; the lungs pneumonic in lower lobes; the blood dark and fluid; some adhesions of the membranes to the cerebrum at the vertex, and some increase of fluid in the ventricles. In this case *typhoid spots* were noted on the tenth day of the disease, and a *scarlet rash* on the chest and back on the nineteenth day, the day she died.

The medicinal treatment in the first case was *baptisia*  $\phi$  and *belladonna*, and in the second case *rhus* 1 and *acid nitr.* 1.

The following report of my case is taken from the very extensive notes taken by the late resident medical officer, Dr. Leo Rowse, to whose continuous attention and prompt action in emergencies, together with the skilful care of the two nurses, is due the happy issue of the case:—

R. C. C., aged 12 years; admitted into hospital June 28th,

1892. The patient had been staying at Ramsgate, where some extensive alterations were being made in the harbour, during which the sea-water was kept out of the basin, leaving the mud and animal and vegetable matter fully exposed to the sun. The stench given off by this rotting material appears to have been most horrible, people covering their noses as they passed to leeward of the harbour. Patient and her father, mother and brother all experienced this on the first day of their stay, which lasted from June 3 to 13, and on several subsequent days, and they all suffered more or less from the effects of the effluvia.

The mother (June 23) had a foul-smelling diphtheroid throat, with raised temperature and followed by considerable weakness; and the father (June 23) and brother (June 26) were both laid up for several days, with all the symptoms of commencing typhoid. The patient, when first seen by myself, had returned home about ten days, and during the last week, from June 17 had complained of headache, malaise, languor, &c. I saw her first on June 22, when she had many of the symptoms of typhoid, a temperature of  $103^{\circ}$  in the morning running up to  $104.7^{\circ}$  at night, a very quick pulse, tenderness of the abdomen, delirium at night, &c. Her temperature and other symptoms distinctly increased in severity, until I sent her into hospital on June 28. On admission her condition was as follows:—She lay in a somewhat apathetic state, being, however, quite cheerful and sensible when spoken to. Her lips and teeth were covered with brownish black sordes. The tongue was dry except at the edges; the dorsum being covered with dirty brown fur, and much cracked. She had a slight cough which was of three days' duration.

*Physical Signs.*—Lungs normal, excepting a few indistinct sibilant and dry rhonchi. Heart's action regular in force and rhythm. The first sound good, not at all blurred, and of average tone. Abdomen slightly distended, here and there some slightly raised lenticular rose-coloured spots. There was a distinct sense of gurgling in the right iliac fossa,

with tenderness. The spleen was, by percussion, five inches long by three inches broad, and distinctly tender on deep percussion. The diarrhoea was somewhat profuse, three stools having been passed between 5 and 8 p.m. Pulse, 96, fair, regular, not very compressible. Respirations, 42 per minute, quiet, with occasional wheeze. Temperature in the evening  $105^{\circ}$ , with pulse 104. On admission patient had probably entered on the twelfth day of the disease.

*June 29.*—Patient had passed a bad night, having slept, in short snatches, about two and a-half hours in all. She had taken nourishment well. The delirium had been of the quiet, busy type, with occasional picking of the bedclothes. During the night she had passed 11 oz. of clear, normal urine. The bowels had been moved seven times, the stools being quite loose, green, and very offensive. During the night the temperature had varied from  $102.8^{\circ}$  to  $104.2^{\circ}$ ; pulse 110, and respirations 42. In the morning she was looking quiet and fairly comfortable, knees slightly drawn up, lips and tongue unchanged. During the day the pulse was 104 to 108, and the temperature  $103^{\circ}$  to  $104^{\circ}$ . Some fresh spots were observed. Throughout the day the patient was restless and wandering, and she passed three fluid stools, resembling those passed during the night.

*June 30.*—During the night, between 8 p.m. and 1 a.m., patient passed three fluid stools. An opium (mxxx.) and starch enema was administered; after which patient slept and the bowels remained quiet for the rest of the night. In the morning patient appeared more easy, but towards the afternoon she became restless again and passed two fluid stools before 8 p.m. Fresh spots were noticed on the abdomen and also on the back. The lips were, if possible, worse than before. The temperature had ranged from  $101.6^{\circ}$  at 4 a.m. to  $104.2^{\circ}$  at 4 p.m., falling to  $102.2^{\circ}$  at 8 p.m. Pulse 112-120, respiration 38-46.

*July 1.*—During the night, patient had been very restless. She had taken nourishment fairly well. Temperature  $102^{\circ}$ - $103^{\circ}$ . At 8 a.m. the temperature appeared to fall suddenly



from 102.2° (4 a.m.) to 99.2° (8 a.m.). As no cause could be discovered for this drop, and the temperature in the axilla continuing at 99.2 on a second trial, the nurse was instructed to take all future temperatures in the rectum. On this being done the true temperature was found to be 104.2°. At 4 p.m. the rectal temperature being then 105°, patient was sponged with water at 112° for twenty minutes, which reduced the temperature to 102.4°. Throughout the day patient continued very restless and delirious, but still took food well. Passed two *involuntary* stools. Pulse 120-130, respirations 30-52.

*July 2.*—During the night patient had been fretful and delirious. At 4 a.m. the temperature being 104°, patient was sponged for twenty minutes with water at 70°. This reduced the temperature one degree. At 6 a.m. the temperature rose to 108° (taken twice in the rectum). Patient was sponged with ice-water for thirty minutes, which reduced the temperature to 103.8°; 12 noon, temperature 105.2°, patient was sponged with ice-water; 4 p.m., temperature 105.4°, patient was sponged with ice-water; 8 p.m., temperature 105.4°, patient was sponged with ice-water. The temperature having now been above 105° for over eight hours, and having resisted the ice-water spongings, patient was (11 p.m.) packed in iced-towels for fifty minutes. The effect was good—the temperature fell to 102.2°; the patient became brighter and much more restful, and fell into a quiet sleep. Pulse 110-120, respirations 42-52; passed two stools, one being involuntary. From this time, the cold water spongings were continued every four hours for five days.

*July 3.*—Patient had passed a rather better night, but appeared to be much the same as the day before, and very weak. At 4 p.m. the temperature was 104.4°; after sponging it ran up to 105°. Patient at this time was breathing hurriedly, the respirations being very rapid and shallow. Her whole face was dusky, the lips blue; the first sound of the heart was very weak and it had lost much of its tone. Dr. Rowse notes—"At once seeing we had to cope with what, if

left, would mean death very shortly, patient was put into a bath of water, which had been cooled down with ice to  $60^{\circ}$ , and kept in it for ten minutes. On the patient being taken out of the bath, some stimulant was given." While in the bath the heart improved greatly in tone, and the breathing became much easier. The ice-water bath reduced the temperature from  $105^{\circ}$  to  $96.8^{\circ}$  in seventy minutes, but it rose again in five hours to  $105.4^{\circ}$ . Half an hour after the bath patient was sleeping calmly and breathing quietly.

*July 4.*—During the early part of the day patient remained very restless and wandering. At 8 p.m. the temperature was  $105.2^{\circ}$ , the respirations hurried and laboured, the countenance dusky, the lips blue, and the first sound of the heart blurred. Another iced-water bath was given for fifteen minutes. This brought down the temperature to  $98.2^{\circ}$ , when patient appeared very much relieved, the colour became clearer, the first sound of the heart improved in tone, and the respirations much easier. Following the bath, patient had a severe shivering attack, not a rigor, properly speaking, but a sort of asthenic shake, which lasted for forty-five minutes. Hot bottles were applied, and the patient very soon came round all right. Stools none. Pulse ranged from 120–140, respirations from 40–48.

*July 5.*—Patient's condition this morning was altogether improved; there was less wandering. She had had some snatches of good sleep; delirium, however, returned late in the afternoon, and continued during the night. The temperature remained at a lower level until 8 p.m., when it rose to  $104.6^{\circ}$ . Patient was then sponged with cold water, and again at 12 midnight. This reduced the temperature to  $103^{\circ}$ . Patient had passed one loose voluntary stool during the day. Pulse ranged from 100–115, respirations from 40 to 46.

*July 6.*—Patient's general condition was distinctly improved, she was much more sensible. Her tongue was not quite so thickly coated. She had taken food well, and had slept fairly at intervals. No stools; temperature  $103^{\circ}$  to  $104^{\circ}$ ; pulse 110 to 120; respirations 40 to 46.

*July 7.*—Last night was not so good, patient was very restless, but still had some snatches of fair sleep. She had passed two stools, in one of which were some specks of blackened blood and sloughs of mucous membrane. Patient was sponged three times in the night. In the morning patient seemed brighter, she complained of being hungry. Her intellect was clearer; the tongue was still dry but the brown fur was not quite so thick. She was sponged three times in the day with cold water. The pulse ranged from 108 to 112; respirations from 36 to 40.

*July 8.*—Patient had passed a moderate night and was quiet and sensible in the morning. In the afternoon she was flushed, was rather more restless and a little delirious. The temperature at 4 p.m. being 104°, she was packed in iced towels from the shoulders to the knees for half an hour, this reduced the temperature to 102°. Patient passed three loose stools during this day. The pulse ranged from 108 to 120 and the respiration from 36 to 40.

*July 9.*—The report was much the same as the day previous. Patient's temperature being 104.4°, she was packed in iced towels for forty-five minutes at 4 p.m. No stool; pulse 108-112; respirations 40.

*July 10.*—During the earlier part of the day patient was quieter and brighter, talked a little and quite sensibly. At 4 p.m. the temperature rose to 104°, and iced packs were applied for forty-five minutes. After the pack patient was much brighter and more cheerful; temperature falling to 100.2°. During the day patient passed three stools. Pulse varied between 90 and 120; respirations 30 to 40.

*July 11 to 18.*—During these eight days the temperature was of a distinctly septicæmic type, and ranged from 97.8° to 99.6° a.m., and from 101.2° to 104° p.m.; the pulse ranged from 80 to 130, and the respirations from 28 to 44 (see chart 2). Stools, 11th, two; 12th, one; 13th, one; and 17th, one formed and light-coloured. The tongue gradually cleaned and became moist. Patient, during this period, gained in strength, took nourishment fairly well, and slept much more peacefully.

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*July 19.*—Patient slept well during the night, in all about six hours, and continued well until the evening, when she became dull, complained of headache, was very flushed, and the tongue was more dry and brown. The morning temperature, which had been well under  $99.6^{\circ}$  for the past week, did not drop below  $101^{\circ}$ , and in the afternoon it rose to  $103.4^{\circ}$ , pulse 122, respirations 30. This rise of temperature proved to be the commencement of a relapse, for which the only assignable cause was a warm-water enema, given early the day previous; the diet—milk, beef-tea and Benger—having remained unchanged.

The patient now passed through a very severe relapse, lasting fourteen days (July 19 to August 3), during which period the temperature never fell in the morning below  $101^{\circ}$ , and during seven days (July 26 to August 1) remained above  $103.2^{\circ}$ ; the evening temperature during this period ranging between  $103.2^{\circ}$  and  $105.6^{\circ}$ ; on eleven consecutive nights standing at  $104.6^{\circ}$  to  $105.6^{\circ}$ , with one exception, when the temperature was  $103.2^{\circ}$  (probably due to the patient vomiting). The pulse, during these fourteen days, varied very considerably in frequency and force, in the morning ranging from 100 to 130, and in the evening from 110 to 148; the pulse at times being hardly perceptible, and the heart sounds extremely faint, with the first sound much blurred. Respirations, morning, 26-44; evening, 24-60.

The bowels on the first four days were confined, being only moved with enemata; afterwards they were loose, the stools being passed involuntarily on six days, and containing dark clotted blood on three days (July 29 to 31). The nights were extremely restless, patient being violently delirious, crying, talking incessantly and screaming. In fact, on several nights her screams could be heard all over the hospital. During this time patient complained of headache. At this period there was much tenderness of the abdomen, specially over the spleen; patient lying on her back with the knees raised.

The tongue again took on the dry black character of the first attack, and sordes appeared on the gums and lips. Ex-

treme difficulty was experienced in making patient take food; at times she would struggle with all her might against it. The food consisted of raw eggs, milk, Brand, Valentine and beef-tea, and occasionally thin Benger. After this date (August 3) patient passed through a second distinctly septicæmic state, lasting for twelve days (August 3 to 15) during which time the temperature ranged from  $96.4^{\circ}$  to  $99.8^{\circ}$  a.m., and from  $100^{\circ}$  to  $104.2^{\circ}$  p.m.; on three days the difference between the night and morning temperature being as much as  $7.5^{\circ}$  (see chart 2). The pulse during this period ranged from 92 to 140 a.m., and from 108 to 152 p.m.; respirations from 24 to 58. The stools were 4th, three stools; 8th, two formed stools; 9th, two formed stools; 10th, two formed stools; 11th, four formed stools, afterwards not noted. Neither blood nor sloughs were noticed.

The tongue gradually moistened, and the lips and teeth became clean by August 6.

The sleep for the first six days was very restless and disturbed; patient being delirious, and on some nights having a return of the loud screaming, but during the second week she slept more quietly.

The appetite at first, during this period, was very bad, the diet being restricted to beef-tea and chicken-tea, milk, beef jelly, raw eggs and Valentine's meat juice.

On August 18, patient complained of being hungry. Twice during this second septicæmic period the respiration became very rapid and shallow; the pulse so quick as to be almost uncountable; the heart sounds blurred and indistinct; the face and lips dusky, so that the worst was apprehended.

From August 15, patient made a steady but very slow progress towards convalescence, and gradually returned to carefully selected solid food. She was able to be moved into the next ward on September 12, and was discharged cured on September 17, having been in the hospital from June 28 to September 17, in all twelve and a-half weeks. After leaving the hospital patient made steady and continuous progress, until at the end of the year she was again quite strong and robust.

The medicinal treatment throughout the acute stage of the case was somewhat secondary. The remedies given throughout the case were *arsenicum* on twenty days, *china* on six days, *lachesis* on five days, *digitalis* on four days, *digitalis* and *aconite* were given in alternation by Dr. Rowse on four days, *rhus* and *antimonium tartaricum* each on three days and *baptisia* on one day. Besides the above, *belladonna* was given on two nights for violent delirium, and *stramonium* on several nights for constant screaming. The different days on which the above remedies were given are indicated on the two charts. The dietary employed is given in the preceding notes.

In going over this case, the following points appear to me to be of great interest :—

1. The extremely good effect of the cold applications when the patient was almost moribund. On the seventeenth day of the disease, in the afternoon, the symptoms were as follows :—Temperature 105°, pulse 108, respirations 44, patient breathing very hurriedly, the respirations being very rapid and shallow, the whole face dusky and the lips blue; the first sound of the heart was very weak and it had lost much of its tone. These symptoms, I think, clearly showed a rapidly approaching fatal end. As soon as possible, the patient was placed in a cold bath, the water having been cooled down by adding ice until the temperature was 60°, at which it was kept until at the end of ten minutes the patient was taken out and placed back in bed. While the patient was in the bath, her heart sounds improved greatly in tone, and the breathing became much easier. Half an hour after the bath the patient was sleeping calmly and breathing quietly, and in another half-hour the temperature was reduced from 105° to 96.8°.

Dr. W. Cayley, in his Croonian lectures on some points in the pathology and treatment of typhoid fever, gives most clearly the reasons why in some cases of extreme hyperpyrexia the cold applications fail and in others they succeed. He says :—“ There can, I think, be little doubt but that these hyperpyretic temperatures are due to a paralysis of the heat-regulating functions of the nervous system, and are mostly an

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indication of a general failure or paralysis of the nerve centres usually, therefore, their occurrence is a certain sign of approaching death; and in this form hyperpyrexia is very often seen at the termination of all febrile diseases, including typhoid. In these cases the patient does not die from hyperpyrexia, but he has hyperpyrexia because he is dying, and no lowering of the temperature by the abstraction of heat, as by a cold bath, has any effect in retarding the fatal event. . . .

In other cases, however, hyperpyrexia may occur without any general or irremediable failure of the functions of the nervous system, though the high temperature itself, will, if not reduced, soon lead to fatal coma. In these latter cases, if we can succeed not only in lowering the temperature, but also in stimulating the nerve centres to a resumption of their functions, the patient will recover. In the zymotic fevers, as typhoid, extreme hyperpyretic temperatures, as  $108^{\circ}$  to  $110^{\circ}$  Fahr., commonly indicate a general paralysis of the nervous centres and impending dissolution."

The number of the baths, Dr. Collie, of Homerton, states, should be limited to three each day; the patient should be plunged at once into water at a temperature of  $60^{\circ}$ , as this is less depressing than a bath at  $90^{\circ}$  gradually lowered to  $60^{\circ}$ ; the duration of the bath should not exceed ten minutes in an adult and seven minutes in a child, and they should be altogether discontinued after the second week. Cold baths are generally held to be counter-indicated in cardiac weakness, lobular pneumonia, pleurisy, intestinal hæmorrhage and peritonitis.

Dr. Goltdammer is of opinion that the cold bath treatment increases the proportion of the relapses.

2. The good effects of the cold applications in reducing the extreme hyperpyrexia are clearly shown on the two charts. On the sixteenth day of the disease the temperature was lowered by means of ice-water spongings for thirty minutes, from  $108^{\circ}$  to  $103.8^{\circ}$  and afterwards did not rise above  $105.4^{\circ}$ .

3. The great range between the night and morning temperature, when the patient was twice passing through a

septicæmic state : on the 24th—31st day of the disease = 5°, and on the 48th—56th day of the disease = 7.5°.

4. As to the cause of the relapse, whether it could be due to the enema causing re-absorption of the typhoid virus?

The idea that giving a simple water enema can cause a relapse, may be fallacious, but I have known relapses to occur, one or two days after an enema has been administered, in two other cases of typhoid under my care, and I am beginning to think that large water enemata are not quite so harmless in typhoid as is often supposed. The rectum is often loaded with germ-bearing fæces, apparently innocuous as long as the stools remain somewhat dry and solid ; these poisons the enema stirs up, liberates and holds in solution, placing them in a form specially favourable to re-absorption.

Somewhat the same thing occasionally occurs in cases of constipation when enemata are used ; a sharp attack of urticaria being the result of the re-absorption of septic matter into the general circulation, by osmosis into the blood and lymph vessels of the rectum. Several cases of urticaria from this cause accompanied by sore throat and pyrexia, lasting three days, were reported by Dr. Burford in the *Lancet* of December 13, 1888.

There are several points to be considered in relation to the occurrence of relapses in typhoid being due to the administration of enemata. First, can auto-infection take place in a typhoid patient from the re-absorption of the typhoid germs contained in the fæces? Second, what would be the incubation period? We know that typhoid stools in solution (*i.e.*, water or other fluids contaminated with typhoid excreta) even when carried to the most infinitesimal degree conceivable, as in the well-known Caterham outbreak, will cause typhoid fever in persons susceptible to the disease, and that the period of incubation in most cases is about twelve to fourteen days (as shown in the Guildford epidemic of 1867), but we are, as far as I know, quite ignorant on this point of auto-infection from enemata.

Further investigations, carried on through a large number

of cases, will be necessary to demonstrate whether large warm water enemata in typhoid fever are harmless or otherwise. Whether the small glycerine enemata or suppositories would be equally obnoxious I do not know. Dr. Burford, in the paper before alluded to, states "with glycerine enemata, where very small quantities only are used, no such results (urticaria, &c.) have accrued." The frequency of relapses varies very considerably in different cities and in different epidemics. At Basle, in 1,743 cases the relapses were 8.6 per cent. At the London Fever Hospital, Murchison states that the relapses were observed in only 3 per cent. of 2,591 cases. Other writers give figures varying from 11 to 1.4 per cent.

Dr. Pye-Smith, in his article on "Enterica," 1893, says: "The cause of the liability of enteric fever to relapse is still imperfectly understood. It cannot be due to a fresh infection with the specific poison from without, for the patient is often in a hospital far removed from the original source of his disease, and little exposed to other infection."

Another point in connection with auto-infection is that of protection, namely, does once having had typhoid fever protect from a second attack? Dr. Pye-Smith, in his article above referred to, states:—"Notwithstanding the phenomena of relapse, there is a marked immunity from a second attack of the disease among those who have once finally recovered. In our 415 cases at Guy's Hospital (1879-88, 46 relapses = 11 per cent. occurred), there was only one of a second attack, and that happened five months after the first." This would go somewhat to show that persons are more liable to a second attack of typhoid soon after their convalescence, and perhaps more liable still, immediately after their recovery from the first attack.

5. Another point of interest in the treatment of typhoid is that of aborting the disease, namely, cutting it short or preventing the fever running its usual course. Several of our school have written on this point, specially in regard to the action of baptisia. Personally I cannot say I have ever seen any marked abortive action with this drug; certainly the

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father and brother of the patient, who had characteristic symptoms of commencing typhoid, soon lost these symptoms under baptisia and other remedies, but this does not show much, and is far from convincing.

Dr. Galley Blackley reported a series of cases of typhoid fever in vol. x. of the *Annals*, specially to show the abortive action of baptisia, and the conclusion he came to was that it was *nil*. He also mentions the fact that at the Gumpendorff Hospital at Vienna the death rate under baptisia was found to be much higher than under other remedies.

Dr. Dyce Brown, on the other hand, is of opinion that baptisia has some abortive action, and reported three cases in the *Monthly Homœopathic Review* of April, 1882, which were treated with baptisia; in the first, the temperature was normal on the thirteenth day, but the patient suffered from a relapse; in the second, after the temperature had become normal, the patient suffered from a relapse commencing on the thirteenth day; and in the third case, the temperature was normal on the eighth day and remained so. These three cases do not appear to me to be altogether convincing as to the abortive action of baptisia, and were probably examples of the abbreviated variety of typhoid fever.<sup>1</sup>

Mr. Boughton Kyngdon gives an analysis in vol. viii. of the *Annals*, of 100 cases of typhoid (temperature not given), occurring at Croydon, in which he remarks, under treatment:—"As regards medicinal treatment I met symptoms as they arose; but I cannot say that remedies had any very marked effect on a true case of enteric fever. Baptisia

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<sup>1</sup> Drs. Jürgensen and Liebermeister report a number of cases of the abbreviated variety of typhoid fever, in which the disease terminated before the sixteenth day. In these, besides many of the ordinary symptoms as malaise, headache and anorexia, many cases presented rose-spots, diarrhoea, with characteristic stools and enlargement of the spleen; the spots appearing on the second to the fifth day of the disease. In these cases the temperature rose very quickly, being 104° on the second or third day, in some even 106°, yet these cases subsided between the fifth and twelfth days.

may have mitigated some attacks, which might have been equally as mild without."

Dr. Eubulus Williams also treated a large number of cases of typhoid at Müller's Orphanage at Bristol. Over 600 cases were treated, all under 16 years of age, with a mortality of only thirteen, in which he made an extensive trial of the baptisia treatment. Dr. Williams states, "I have no hesitation in strongly urging on the attention of our body the desirability of the free use of baptisia in typhoid fever. I believe in all cases it modifies the severity of the disease, and in many shortens its duration."—*Monthly Homœopathic Review*, Dec., 1881.

In conclusion, the foregoing evidence, it appears to me, shows that considerable benefit can be gained from ice water spongings, packs and baths in certain cases of typhoid fever, when the temperature continues for several days, during the primary attack, at 105° and upwards, and also, that they are of marked use in reducing extreme hyperpyrexia.

Whether the theory of auto-infection will bear the test of further investigation, is doubtful; but it is suggested as an explanation of the cause of the very puzzling and at the same time very serious complication of typhoid fever, namely relapse.

The evidence as to the abortive action of baptisia is most contradictory; on the whole I agree with Dr. Blackley's conclusion as illustrated by his series of most interesting cases, in which he clearly shows that baptisia has no abortive action in typhoid fever.

## CONTRIBUTIONS TO THE TREATMENT OF UTERINE HÆMORRHAGE.

BY

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### I.—ON THE PATHOGENESIS OF REMEDIES FOR UTERINE HÆMORRHAGE.

BY GEO. M. CARFRAE, M.D.

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MENORRHAGIA may be defined as excessive discharge of blood at the regular monthly period; metrorrhagia as an excessive discharge of blood which is not menstrual. The one is an excess of a normal secretion, the other a true hæmorrhage.

The *causes* of these diseased conditions may be divided into two classes:—

- (1) Constitutional.
- (2) Local.

Among the *first* are included hæmophilia, purpura hæmorrhagica, hepatic disease, phosphorus poisoning, Bright's disease, and all cachexiæ. Among the *second* are, areolar hyperplasia, subinvolution, cervicitis, fibroma, polypus, carcinoma, tubal and ovarian disease, retroflexion, retained products of abortion, prolonged lactation. Sometimes, moreover, the hæmorrhage is caused by reflex irritation of the generative organs such as frequently occurs at puberty, after marriage, or at the menopause. Almost every disease, in short, to which the uterus is liable may give rise to one or other of the diseased conditions we are considering.

Such being the case, it can be readily understood that the *diagnosis* becomes a matter of the utmost importance, inasmuch as on the correctness thereof will depend the success of the treatment in very many cases. Want of space forbids my entering fully into this part of the subject ; but I may say that a correct *diagnosis* can only be arrived at in the majority of cases by a careful examination of the uterus as to size, weight, position &c., of the uterine appendages, and, if need be, by a careful exploration of the uterine mucous membrane. Dilatation, which must be resorted to for this purpose, has the additional advantage of enabling us to apply the needful local remedy. *Prognosis* will depend very much on the etiology. On this point I need not dwell.

*Treatment* is (1) surgical or (2) medicinal, according to the nature of the case.

(1) *Surgical*.—Into this I do not propose now to enter further than to enumerate the methods usually adopted in the present day. These are: (a) The application of caustics such as nitric or carbolic acid to the mucous membrane of the uterus. This method of treatment is indicated when the origin of the disease is endo-metritis, cervicitis, or other derangement of the mucous membrane. I much prefer in such cases using tincture of iodine, or iodized phenol.

(b) Dilatation of the uterine cavity and curetting. This is called for principally when the hæmorrhage is due to polypoid, or other growths in the womb, or to retained placenta, or other products of abortion.

(c) Ligature of the lower branches of the uterine artery. This has been practised successfully by Martin, in cases of inveterate hæmorrhage arising from endo-cervicitis.

(d) Castration has also been successfully used under somewhat similar circumstances, but is more decidedly called for when the hæmorrhage is due to a fibroid or other tumour which it is either impossible or undesirable to remove.

(e) Vaginal hysterectomy has been performed in desperate cases, but is, I think, only justifiable when the hæmorrhage is due to malignant disease of the womb.

(2) *Medicinal treatment.*—In our text books on *Materia Medica* a large number of medicines are accredited with the production of meno- and metrorrhagia in their pathogenesis. In the index to Allen's "Cyclopædia," for example, there are about fifty such. It would evidently be impossible to examine minutely all of these in the space at my disposal. What I therefore, propose is to limit myself to a brief examination of those which have a well-marked, specific action on the female sexual or pelvic organs, and which are generally recognised as our reliable remedies in the various forms of uterine hæmorrhage demanding medicinal treatment. Hitherto our knowledge of the actions of these medicines has been somewhat vague and unsatisfactory owing to the "schema" form adopted by Hahnemann and his followers. Now, however, that we have the "Cyclopædia of Drug Pathogenesis" to appeal to, we can get a clearer idea of the scope of action of our remedies; because, in the first place, the "provings" are presented in the exact form in which they were evolved by the prover; and, secondly, because we know the source whence they are derived, and so can judge to some extent whether that is reliable or otherwise. It appears to me that it will be both interesting and instructive to compare our hitherto accepted ideas on this subject with the facts recorded in the "Cyclopædia," and thus test the validity of the "faith that is in us."

*Secale* is more extensively used, perhaps, than any other remedy in the present day for the cure of hæmorrhage, especially that proceeding from the uterus. The action this drug exercises in this way is, as we all know, supposed to be due to the power it has of causing contraction of unstriated muscular fibre; hence its action is supposed to be *antipathic* rather than the reverse. I think, however, that we have good evidence to show that it really acts *homœopathically*. It produces, in other words, when given in poisonous doses, the symptom for which we give it in medicinal doses to effect a cure. Here, for example, is a characteristic case illustrative of the action of *Secale* in poisonous doses quoted



by Dr. Ringer in his well known "Handbook of Therapeutics" (p. 584-5).

"Dr. Davidson reports a singular case of poisoning by ergot. A pregnant woman for several months took large doses of liquid extract of powdered ergot, till at last it caused death. When called to see the patient she complained of lumbar and arthritic pains, and vomited a reddish-brown pultaceous matter (blood). She passed urine looking like blood. After his visit she vomited half a pint of blood. The upper part of the body was intensely jaundiced. She had genuine 'black eye.' Her lips and tongue were swollen and covered with dry black blood. Her heart beats were 150 per minute.

"After death he found numerous ecchymoses in the subcutaneous fat, in the peritoneum, and in the lungs, also much blood in the peritoneal cavity, and in the stomach and intestines."

This case shows the power Ergot exercises in producing a generally hæmorrhagic condition. The next I shall quote shows its specific action on the uterus. Among the cases of poisoning by this substance, we find the following in the "Cyclopædia of Drug Pathogenesis" (vol. iv., p. 53). "On examination per vaginam found os tincæ open so as to admit first phalanx of index finger, very sensitive to touch, hot and engorged with profuse flowing." These symptoms, we are told, occurred in a woman who had been married two months, and that during that time she suffered from continuous menstruation. We might therefore hesitate to attribute them to the Ergot. Nevertheless, when we observe at a later examination that the "womb and ovary are very much congested and very sensitive to touch; sphincter vaginæ and vagina very much relaxed," and still later on, "hæmorrhage from the nose, mouth, stomach and bowels," we may reasonably conclude that the *Secale* caused the uterine hæmorrhage. The next case shows this point still more clearly :<sup>1</sup>—

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<sup>1</sup> Dr. J. T. Boyd, *St. Louis Clinical Review*, 1879, p. 253. Quoted in "Cyclopædia of Drug Pathogenesis," vol. iv., p. 59.

"About two years ago there was brought to our hospital a young woman, pale, feeble, and evidently labouring under the effects of hæmorrhage, and upon examination the fact was brought out that she had been suffering from uterine hæmorrhage for weeks. The history of the case, as near as could be obtained was this: She had for some time been indulging in illicit intercourse, and her menses having ceased she feared she was pregnant, and had taken large and repeated doses of ergot. Hæmorrhage had at last been produced; the blood at first was slight, but was constantly increasing till she was sent to the hospital, where she died next day. . . . The hospital records mention that she died of uterine hæmorrhage. The *post-mortem* revealed the fact that she had not been pregnant at all, and also that there was no lesion of structure in either the vagina or uterus, as we expect to find from the use of instruments used to procure abortion, but the ovary of the right side was completely disorganised."

Dr. Hughes, in his "Manual of Pharmacodynamics" (p. 803), writes thus with regard to the action of *Secale* on the uterus: "Its tendency to inflame the uterus shows that it *may be homœopathic* to hyperæmia, and even hæmorrhagic conditions of the organ." I think the evidence furnished by the "Cyclopædia," which I have quoted above, warrants us in saying that it *is homœopathic* both to hyperæmic and hæmorrhagic conditions of the womb. And in point of fact we find *secale* useful, not only in hæmorrhagia arising from sub-involution or metritis, but also from that due to fibroids and other organic diseases—indeed it may be said to be helpful in menorrhagia and metrorrhagia from whatever cause they are produced. Hence I give it the first place among remedies for those complaints.

*Sabina* is, in large doses, an irritant poison, and has a specific action on the pelvic organs, causing hæmorrhage from rectum, uterus and bladder. "It is," says Dr. Hughes,<sup>1</sup> "a most valuable homœopathically-acting remedy for ovario-

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<sup>1</sup> *Op. cit.*, p. 793.

uterine excitement ; as in menorrhagia when the blood is bright red, in metrorrhagia, in threatened miscarriage from irritation, and in metritis." The provings corroborate this statement. In the "Cyclopædia" we find among the symptoms produced in the provings of sabina, "on the third day after menstruation (p. 26) profuse menstruation occurs again, with violent tormina and labour-like pain; the blood was partly thin, partly lumpy ; also diminished discharge of red urine, with strangury and mucous vaginal discharge. Menses set in during the 'period' without pain, but three or four times more copious than usual. After rising, lumps of blood passed. During menstruation os uteri open ; blood red and copious by starts, especially during movement ; passes big lumps of coagulated blood ; menses last nine days and are very copious." I am tempted here to quote what Dr. Phillips in his work on "Materia Medica" (p. 204, vegetable kingdom) says with regard to the pathogenetic and curative virtues of sabina, to show how distinctly he illustrates the truth of a doctrine which he nevertheless persistently repudiates. [This, I need hardly say, is only one of very many such illustrations which might be quoted—so many, indeed, as to call forth the remark from his reviewer, when his book was published, that if we are to accept Dr. Phillips' teaching we must swallow homœopathy wholesale. This appeared, so far as I can remember, in the *Medico-Chirurgical Review*. About the same time the *Lancet* reviewed the work most favourably, and described it as an excellent work for students and practitioners. I leave the "orthodox" school to get off the horns of this dilemma in the best way they can, and resume the thread of my discourse.] "I consider," says Dr. Phillips, "that savine is one of the most powerful emmenagogues in the pharmacopœia, and has the additional advantage that it can be given with perfect freedom from risk of doing harm.

"In *menorrhagia*, *leucorrhœa*, and *uterine hæmorrhage*, singularly enough, savine has proved useful in many hands. I have myself given the tincture with the best effects, in doses of from 5 to 10 drops in a tablespoonful of cold water, every half hour to every three hours." Singular, isn't it?

The limited space at my disposal forbids my going into the more minute indications for the use of sabina as recorded in our provings, but I may remark that in all the provings, rheumatic pains of various kinds occupy a prominent place. Generally speaking, cases of meno- or metrorrhagia, dependent on uterine or ovarian irritation or inflammation, accompanied by profuse discharge of florid red blood, and rectal or vesical irritation, and rheumatic tendencies or pains, are those likely to be relieved by sabina.

*Ipecacuanha*, like the medicines we have just examined, produces hæmorrhage, not only from the uterus, but from other portions of the mucous tract—from the stomach, intestines, kidneys, &c. Among the symptoms mentioned in Hahnemann's provings we find—"Menorrhagia: recurrence of the catamenia that had ceased fourteen days previously." In the "Cyclopædia" we find among other provings that of Mrs. S. She was one of those who possessed that peculiar susceptibility to the poisonous action of *ipecacuanha* which is so well known as a not infrequent idiosyncrasy. Her proving arose accidentally from inhaling the emanations from the powder. Asthma was an invariable symptom. But it is recorded in addition that "she had a slight appearance of menstruation about four or five days after the accident occurred, although it was about the middle of the interval. Coughed up at times some small quantities of blood, and had also some mixed with the stools and urine." *Pathogenetically*, therefore, *ipecacuanha* has a well-merited reputation in uterine hæmorrhage. *Clinically*, I fear, it is somewhat neglected and left out in the cold.

*Hamamelis*.—The following is the only relevant proving of this medicine:—

"Mrs. W., always regular, consulted me for some dyspeptic symptoms, and I gave her *one* drop of the 3rd dilution three times a day. In two days she reported that (midway between two periods) she had been flowing considerably for twenty-four hours, and had lost over a quart of blood, bright and fresh, not coagulable, unlike her ordinary menstrual discharge, which was dark and generally coagulated.

Hæmorrhage ceased (medicine being suspended) in a few hours. In four days she came again, and I gave hamamelis as before. She again commenced flowing twenty-four hours after taking it, and on leaving it off the hæmorrhage again ceased. A similar thing occurred in a young lady who for imaginary ailments had the same prescription."

We are told that one of these "provers" had suffered for years from leucorrhœa—which was cured while taking the hamamelis. But the fact that she was not in a sound state of health when she took the medicine, coupled with a consideration of the quantity taken, must give us pause before we can accept the evidence as conclusive of the homœopathic action of this medicine in meno- or metrorrhagia. That it has a well-merited reputation as a curative agent in these, and other forms of hæmorrhage, we readily admit, but this, for the present, must be admitted to be on empirical grounds chiefly.

*Xanthoxylum*.—In several of the provings recorded in the "Cyclopædia" of this medicine, we find that menstruation anticipates and is profuse; *e.g.*, "Mrs. H. experiences pain in left side; menses appeared next morning, a week before usual time, attended by a good deal of pain."

"Mrs. I., after four doses of 20 to 25 drops each had headache (tightening of scalp and heavy pain in temples) and a great menstrual flow, being two days in advance of the usual time. After another dose, profuse flowing, pain continued until noon of next day, when it gradually subsided."

The next prover records that "after taking in all 200 drops, on the fifth day menses appeared, anticipating six days. Flow increased bright red, and lasted five days. Dysmenorrhœa, with bearing down feeling and pain in right ovarian region. Very nervous; easily startled, and hysterical." . . . The drug seemed to have no long-continued effect, unless the fact that in this month the menses again anticipated nearly a week, with increased flow, be attributed to this.<sup>1</sup>

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<sup>1</sup> "Cyclopædia," vol. iv., p. 434-5.

Yet another prover records that menses appeared two days early. She had also profuse leucorrhœa; pain in right ovarian region, with profuse flow, leaving leucorrhœa, which lasted four days. These symptoms were repeated after each proving—four in all.

Unlike hamamelis, xanthoxylum is a medicine which has a very "good record" in its favour as a truly homœopathic remedy in uterine hæmorrhage, and this is verified by clinical observation. It is one of the many valuable additions to our *Materia Medica*, for which we are indebted to our transatlantic brethren.

*Crocus*.—The symptoms appertaining to the female sexual organs recorded by the provers of this drug are "Sensation as if menses would appear, with colic and pressing towards the genitals (after a few hours). Menorrhagia on the slightest movement." Revereus states "that crocus may cause fatal hæmorrhage from the uterus, especially after parturition." There is nothing in these provings to indicate the selection of crocus when the hæmorrhage is clotted and black, although all the text books advise its use in such cases. Sabina, on the other hand, is recommended to be given when the blood is fluid, and florid in colour. Now it will be remembered that in more than one case the prover records the passage of clotted blood; so that in the one case we are recommended to use crocus under conditions which are not present in the provings, and in a medicine in which these conditions are present no such recommendation is made. The fact is, in my opinion, that too much significance is given to this symptom. The clotted or fluid character of the blood in menorrhagia depends simply on the time it is retained in the vagina, and has no significance as a diagnostic sign, and this characteristic in the case of both medicines ought to be expurgated from our text books in the future. "Sensation as of something living and jumping about in the pit of the stomach, abdomen, arms and other parts of the body, with nausea and shivering, "dimness of vision," "twitching in the muscles," &c., are among the most prominent symptoms for the selection of this medicine.

*Platinum*.—The principal symptoms noted among the provings of this medicine are: "Emission of much clotted blood during the first day of the menses. Menses about fourteen days too early and very profuse." This symptom—early and profuse menses—is repeated by several provers, and may therefore be taken as a well-marked indication for its use. The hysterical temperament, with disposition to melancholy, tendency to coldness in feet and hands, numbness, anæsthesia, or paralysis, constipation and flatulence, are additional symptoms calling for the selection of this remedy. It may, according to Dr. Hughes,<sup>1</sup> be said to be to women what aurum is to men. Cases due to ovarian irritation or sexual excitement are suitable for platinum.

*Hydrastis* has been much used lately by both allopaths and homœopaths in cases of uterine hæmorrhage. There is absolutely nothing in the "provings" to warrant its use in such cases. So that if it is curative, like hamamelis, we must admit that its use is empirical, not homœopathic. The cases in which it is indicated are those in which malignant disease is suspected to be the cause of the hæmorrhage.

*Ferrum* is another medicine which—although of undoubted value in many cases of menorrhagia—cannot be claimed as strictly homœopathic in its action. Hahnemann indeed records that "the menses which were due came on immediately after the *chalybeate bath*, and twice as profusely as usual." But as we all know, a hot bath, apart from its being impregnated with iron, may have this result. The effect of a bath, moreover, cannot be accepted as a "proving" of the drug.

Ritter mentions "metrorrhagia" as one of the symptoms among his provers. But these seem to have been patients who were taking the waters of Pyrmont and Schwalbach. If so, these provings cannot be accepted as reliable, because they are made on people who were suffering from all sorts of ailments that are likely to be benefited by iron. No such

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<sup>1</sup> *Op. cit.*, p. 76o.

symptom as "menorrhagia" is recorded in the "Cyclopædia." So that while we must admit the value of iron as a curative agent in this condition, we must also admit that its use is purely empirical. Iron is indicated chiefly in cases associated with anæmia—but is also useful in those connected with the menopause.

In addition to the purely medicinal treatment, we must not omit such useful adjuvants as the application of Chapman's spine bags. Hot water so applied is very useful in almost every form of uterine hæmorrhage. So also are vaginal injections of hot water with the addition of hazeline. Of course rest in the recumbent position must be enjoined in all cases, with light covering and suitable diet.

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## II.—ON THE THERAPEUTICS OF UTERINE HÆMORRHAGE.

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IN considering the treatment of the above condition, I would divide cases into several classes.

1. *Menorrhagia*.—That is when the menstrual discharge is excessive at the time, *while no hæmorrhage occurs in the interval*. The excess may consist (i.) in the continuance of the period for too long a time, as for 10 or 14 days, during which time the loss is on the whole too great; or (ii.) in the discharge being very excessive, although the period during which it lasts may not be abnormally long; and (iii.) in the recurrence of the period too frequently, as every fortnight, whether the discharge at the time be normal in quantity or excessive.

It is very important, when possible, to ascertain the *cause* of the profuse discharge. This is sometimes by no means easy, as what was the original cause may have ceased to operate, and yet the menorrhagia may have continued, while, whenever the general health is much disordered, it may be doubtful whether the menorrhagia is the effect or the cause of the general un-health. One undoubted cause of menorrhagia is the term of the menopause. I say a cause, though perhaps I should rather have said a concomitant, as, although it is very common to find it coming on at that time, the real cause of this may not be so obvious.

The majority of the cases we meet with are chronic—that is, have been going on for some time, and gradually producing a state of health that induces the patient to seek our aid. Most of the causes of menorrhagia tend to produce general debility of the system. The chief of these are: (1) A depraved condition of the blood, in virtue of

which blood is easily lost on trifling occasions. Under this head would come cases of the "hæmorrhagic diathesis," and also those allied to purpura or scurvy, in whom the gums bleed easily, who lose much blood from a trifling wound, who bleed easily from the nose, and in whom the smallest injury produces ecchymosis. (2) Chronic disease of the kidneys with albuminuria, of the heart, or liver, or lungs, all of which are apt to lead to secondary uterine engorgement. (3) Actual chronic uterine engorgement. (4) Enlargement of the uterus, either as the result of chronic inflammation, or of sub-involution after pregnancy. (5) Excessive lactation, causing anæmia and general debility. (6) Continued mental depression. (7) Excessive ovarian excitement from over-indulgence in sexual intercourse, or sexual excitement of any kind. (8) Over-feeding and luxurious living, with want of proper exercise. (9) Residence in tropical climates, or in places calculated to produce a weakened state of nervous and muscular energy and tone. (10) Malarious poisoning. (11) The debilitating influence of fevers. (12) Lead poisoning.

When we can diagnose the cause we are much helped in the treatment, and hence the necessity of ascertaining this point, when possible. But whatever the patient states is the cause, in her opinion, we must always keep in mind the possibility of an early abortion in a married woman, but also even if the patient is unmarried. If this is overlooked as a possibility the hæmorrhage may go on for a long time, till the real cause is discovered. It is unnecessary for us to take up valuable space by describing the symptoms of menorrhagia, which are too well known.

Coming now to the treatment of menorrhagia, this divides itself into that at the time of the excessive flow, and that during the interval, with the view of preventing the recurrence of the excess, or the too early return of the period, or both.

First, the treatment during the time of the excessive flow. One must be careful here to avoid the error of checking the flow suddenly and entirely. Only harm can result from

this, as the sudden suppression may cause metritis, or other systemic disturbance threatening it. What we must aim at is the moderation of the flow in the earlier days of it, and only when it has lasted over five days to attempt to stop it altogether. The medicine, then, if given in the first days of the period, should be given only at such intervals as will probably moderate it, and nothing more, the patient having particular directions to lengthen the interval when a change is observed, and the amount is reduced to the normal quantity. This is the plan to be adopted when the menorrhagia takes the form of profuse flow from the first. But when it takes the form of long continuance, the whole amount being excessive, but that during the first two or three days not being so, then the better plan is to prescribe no medicine for the first two or three days, and then to give the medicine with the view of stopping it as soon as possible, short of a sudden cessation.

The first medicine I shall speak of is *Aconite*. In the majority of cases it is not indicated, but in its own sphere it is invaluable. The cases calling for it are those in whom the flow is active, the blood bright red, and flowing in an almost continuous stream, and when there is a state, not of debility and anæmia, but of general vascular excitement. This usually is found in women who eat and drink, "not wisely, but too well," and take little exercise. There may or may not be rise of temperature, but the pulse is quick and full, the face flushed, headache, thirst, coated tongue, heat of skin, great restlessness and uneasiness, especially at night, with fear of death. In such cases there is evidence of uterine congestion, and great pelvic pain, with tenderness, perhaps, over the ovario-uterine region. Here *aconite* is of immense value, given in the 3rd cent. dilution, or the 2nd dec., every hour or two. In such cases the diet must be of the lightest, milk alone, or milk food, fruit, and lemon juice. A day or two's starvation with little more than water will do no harm. All red meat, beef tea, and stimulating diet must be strictly forbidden.

In somewhat similar conditions *Belladonna* is required, but

yet the indications for this drug are peculiar to itself. It is a state of vascular erethism, as with aconite. The pulse may or may not be quick, but it is excitable, and rather full, while throbbing in the temporal arteries and in the neck is felt. The patient complains of forcing down pain, in the back, and all round the pelvis, a sensation as if everything would be forced out of the vagina; and there will probably be a frequent desire to micturate. The menstrual blood is not markedly bright, but is simply excessive; in fact there is evidently an engorged state of the pelvic organs. The face is flushed, being more so in the afternoon and evening; throbbing headache is complained of, with heat all over the body. The pupils are dilated, and she dislikes light and noise, and sleeps restlessly, with excited dreams. The states for aconite and belladonna are often so mingled that we, with great advantage, may give the two medicines in alternation, the frequency depending on the severity of the symptoms. I would advise belladonna to be given in the 3rd cent. or down to the 1st dec. dilution, according to the severity of the symptoms.

But in the majority of cases of menorrhagia, neither of these conditions is present, and hence these two remedies are only occasionally required, though, when called for, they act charmingly.

Of the medicines most generally required, *Sabina* stands in the forefront. The effect of sabina in over-doses in producing uterine expulsive action, with great irritation, going on even to metritis, and with profuse discharge of blood is well known, and it used to be employed, and even now is, to procure criminal abortion, and it is classed in old school works as an emmenagogue. We, of course, use it for the very opposite condition. It is called for when the blood is profuse, flows on the least motion, so that the patient finds it necessary to keep perfectly quiet in order to prevent further loss. From its profusion it often passes clotted, but usually it is very bright-coloured, like arterial blood. The sabina case has usually drawing pains in the back, colicky pains in the abdomen or labour-like pains in the uterine region. The

bladder usually sympathises, and micturition is frequent and painful. Its action in such cases is beautiful. I generally use the 2x dil. every hour or two hours.

Next in importance, perhaps, comes *Crocus*. It also is classed in the old school works as an emmenagogue. The case for crocus is quite different from the sabina state. The blood flows slowly, is dark and much clotted, and the passage of the clots causes expulsive, forcing-down pains. There are two curious symptoms of crocus, which, when present, will lead us certainly to the use of this drug, viz., a sensation as if something alive were rolling in the abdomen, and a confusion of sight, as if a piece of gauze were before the eyes, or as if mucus was obscuring the vision. Crocus, in such cases, will rarely disappoint us. I usually give it in the 2nd or 1st dec. dilution, every hour or two hours. When the discharge is as above, and lasts a long time, crocus will rapidly check it.

Equal in value, when indicated, is *Hamamelis*. We all know this medicine as one of immense value in all hæmorrhages of a venous and passive character, and so in menorrhagia the indication for it is the absence of any special symptoms, except the continuance of the discharge. In cases where the discharge keeps on slowly, passively, but steadily, for days beyond the proper time, without pain or any other marked symptom, hamamelis may be given with the utmost confidence. I usually give the 1st or 2nd dec. dilution.

*Ipecacuanha* is sometimes extremely useful, as it is in other hæmorrhages. The discharge is bright coloured, fluid, and flows in a steady stream, but I seldom prescribe it, unless there is a marked sense of nausea, a coated tongue, or a fatiguing cough, or the spasmodic, suffocating cough of the well-known ipecacuanha type. In fact, I consider the presence of one or other of these symptoms the real indication for the drug in menorrhagia; otherwise, as I have said, I seldom use it. The 1st dec. or 3rd cent. act best.

The next drug, *China*, though, as I shall presently point out, is of great service when given during the interval, is yet

markedly homœopathic when the excessive flow is going on, and it is very often required, as so many cases of menorrhagia present the china indications. They are—great weakness, sense of prostration and sinking, vertigo, headache of the neuralgic type, or sometimes a full heavy sensation, with *tinnitus aurium*, coldness of the body in general or of the extremities, or chilliness alternating with flushes of heat and perspiration. In such cases it is of immense help. I usually give the 1x in 5-drop doses every two hours, or even the mother tincture in 2 or 3-drop doses.

*Platina* in its own sphere is also a remedy of great value, and the indications for it are very clear. Before and at the commencement of the period there is severe dysmenorrhœal pain, of a cutting or cramping character, in the back, and all round the pelvis; the discharge is profuse, dark and clotted, and there is marked mental depression, or sometimes sexual excitement. The mental depression is very characteristic of it. The 6th dil. acts admirably.

The medicine I have next to notice is one that is not used by us so much as it should be, but is a great favourite in the old school. I refer to *Plumbum*. It is considered by them as an "astringent." But it is not generally known, I think, that this prescription is homœopathic. Lead has the power of producing menorrhagia, with cramping or contractive pains, and frequent abortions. I brought these points under the notice of my colleagues in a paper in the *British Journal of Homœopathy* in 1871, in which I quoted passages from a very interesting paper read before the Obstetrical Society of London (vol. viii.), by Mr. Benson Baker. The subject is noticed cursorily in Graily Hewitt's "Diseases of Women," but Mr. Baker hunted out the original observations of M. Paul, from whom Hewitt quoted. He adds other cases of his own, clearly showing the power of lead in poisonous quantity to produce menorrhagia, with cramping or contractive pains, and in married women frequent abortions, generally attended with profuse hæmorrhage at the time, and long continuance of the discharge after the ovum was expelled. In

one case of his own Mr. Baker found marked symptoms of lead-poisoning, and failed to check the flow till he put the patient on iodide of potassium, to antidote the lead. In Allen's "Encyclopædia" we find these points fully brought out. These facts show that the old school, in prescribing lead as an "astringent," are in reality prescribing homœopathically. The special indications for the selection of plumbum are, besides the profuse flow, the cramping or contractive uterine pains, colicky pains in the abdomen, obstinate constipation, dull, depressing headache, pale, ashy-looking face, prostration, and mental depression, sometimes alternating with excitement. In such a state we have the experience of the old school, as well as our own, to show its value as a remedy. It certainly is one of great importance in a properly-indicated case. The plumbum aceticum in the 2nd dec. dilution every two hours answers well.

Perhaps it will be wondered at that I should leave *Secale* so far down in the list. It is placed in homœopathic works as a remedy in menorrhagia, and in its pathogenesis we find increased menstrual flow, with spasmodic pains. We are accustomed to hear of *secale* being used in full doses by allopaths in menorrhagia on the knowledge that the full-dose action of ergot is to cause contraction of the vessels, and of the uterine muscular fibres, and consequently its action is antipathic, requiring full doses for its development. But the experience of several homœopathic writers is that *secale* in medium, and even high dilutions, will check menorrhagia. This would tend to show that its action was not antipathic, but homœopathic. I am not satisfied on this point, and prefer to leave it *sub judice*, merely stating that it has been found successful in minute doses. If given in a routine manner, as in the old school, simply for the hæmorrhage, and without regard to other symptoms, probably full doses are necessary, but if minute doses are to be prescribed, then the other symptoms present must be taken into account as indicating it. These are a state of great debility and exhaustion, feeble pulse, a state almost approaching collapse,

with cold hands and feet, pale, sunken face, and cold perspiration. These symptoms are so indicative of secale that when present in menorrhagia it ought, in rallying the patient, to check the discharge. I have never myself given it higher than the 1st dec., but unless its characteristic symptoms are present, I prefer to use more distinctly homœopathic remedies.

I now must say a few words on *Iron*, which, in certain cases of menorrhagia, is of marked value. These are when it is accompanied by marked anæmia. When this association is present, the anæmia is, we may almost take for granted, produced by the menorrhagia, as when anæmia is the primary disorder, amenorrhœa is usually, though not always, present, instead of menorrhagia. The hæmorrhage being the cause of the anæmia, it may be said, stop the hæmorrhage, and the anæmia will rectify itself. This is true enough, but very often the two disorders cease to be entirely cause and effect, but influence one another in a "vicious circle." The anæmia, once produced, causes such a state of general debility, laxity of fibre, and want of tone, that the hæmorrhage, or the tendency to it, is kept up. The iron here does not act so much as a food as a true medicine, acting beneficially on the unstriped muscular fibre, and on the general nervous system. In such a case, iron, while often supposed to be contra-indicated, will act beautifully on both conditions. It may be given in the form of *Ferrum Picricum* 3x—a favourite preparation of mine—or the *Ferrum Muriaticum* 1x, or even a drop of  $\phi$  may be given with marked effect till the flow ceases, and then continued during the interval.

As this paper is intended to speak only of personal experience, I refrain from saying anything of *Erigeron canadense*, *Senecio Aureus*, and *Trillium Pendulum*, as, though I have used the first and third occasionally with benefit, I have not done so on such a scale as would justify me in speaking decidedly regarding them.

When the flow continues excessive after the first few days, the use of a hot injection (105°) once or twice a day is perfectly safe, and very beneficial.

I now turn to the treatment of menorrhagia during



the interval. *China* is one of the most important remedies. The patient feels weak, pulled down, and unfit for any exertion after the flow is over, and she hardly begins to recover her strength before the next period supervenes. She has neuralgic headaches, and if they come on at a regular time of day, so much the more is the medicine indicated. She will feel giddy, have a poor appetite; the tongue is clean, and there is no dyspepsia, proper—only a want of tone. She feels chilly, but flushes easily, and perspires on the least exertion. There is usually more or less anæmia in such a case. Here *china* 1x, 5 drops three times a day, or even the  $\phi$ , 2 or 3 drops may be prescribed with the utmost benefit. *Calcareæ carb.* is one of our most valuable medicines given during the interval. Hahnemann noticed, with his wonderful sagacity and observation, that it is when the period returns *before the proper time* that *calcareæ* is so valuable, while it is seldom of use when it recurs at the regular time, or is delayed, even though then profuse. This is a most practical point, and one that all homœopaths have corroborated. The indications for the choice of *calcareæ* are, besides that just mentioned, a pale, puffy-looking, anæmic face; the presence of a strumous diathesis with its well-known features, great weakness and lassitude, frequent headaches, or a full, heated feeling on the top of the head, or often the reverse, a sense of coldness in the head, or a sense of heavy pressure on the vertex. The appetite is poor, acidity after meals is troublesome, there is probably leucorrhœa, with pain in the back, cold hands and feet, or with the coldness they have cold, clammy perspiration. She will perspire at night, or on the least exertion by day. At night the perspiration is chiefly on the head and chest. If with these symptoms there is chronic cough, pulmonary disease, and loss of flesh, *calcareæ* is so much the more indicated. It answers admirably in the 6th or 12th dilutions, but my favourite dilution is the 30th. It is a remedy of very great importance, and one that we could not do without.

Of great value also in chronic menorrhagia is *Arsenic*, and the cases suited to it are a good deal similar to those

where china is indicated. The prominent characteristics of it are debility and prostration, with anæmia. Along with these we frequently find periodical neuralgic headaches, or neuralgia elsewhere in the body, a clean or red tongue (an almost unfailing indication), no appetite, pain after eating, with nausea, and a tendency to diarrhœa, loss of flesh, cold extremities, and night perspirations. The pulse is weak, the heart's action feeble—in fact, a state of great vital depression. Arsenic, in such a case, is a medicine in which I have great confidence. It may be given in the 3rd dec. dilution, either in the form of arsenicum album or arsenicum iod.

*Belladonna*, the indications for which I gave in the earlier part of this paper, may with advantage be continued in the interval, for the same plethoric habit of body, and especially when, with continued, down-bearing back-ache, there are evident signs of uterine congestion. *Platina*, when indicated during the period, as above described, ought to be continued during the interval. I need not repeat the indications for this medicine already given. So with *Hamamelis*, it is often of great service to continue its use in the interval in the 2nd dec. dilution.

*Actæa*, though usually prescribed in amenorrhœa, is in certain cases of menorrhagia of marked value. One need not be surprised at its use in these two opposite states, when we remember that in ovarian and uterine congestion we find both these states present in different cases, and both states are produced in the provings. The indications for its use in menorrhagia are the existence, as ascertained by examination, of more or less ovarian and uterine congestion; when the period is *preceded* for some days by much down-bearing and aching in the back, and in the limbs, as if from over-exertion. There is a distressingly restless, nervous state, and *marked depression of spirits*, which cannot be thrown off. This latter is an almost unfailing indication. Pressive vertical headache, and aching in the eyeballs, and at the back of them, are present, while during the rest of the interval a similar, though less marked, state exists, with various neuralgic pains, restless sleep, and leucorrhœa. *Actæa* here is invaluable in the 3rd

dec. dilution given three times a day, and every two hours for a few days before the period is due.

*Aletris* is certainly of value given in the interval. Its action is a good deal allied to that of china. *Lycopodium* is in certain cases of great help, but the indications for it are drawn from the general state of the system, and not from the uterine state. This being so, I need hardly take up space in describing the state of general health which is so well known to be characteristic of *lycopodium*.

*Apis* I perhaps might have named earlier in the list, as it is a remedy in which I have great confidence in certain cases. Its action on the ovaries in causing pain and congestion is very striking, and the menses always come too soon and too profusely. The prominence of the ovarian congestion, especially if on the right side, is perhaps the most decided indication for its use, with aching and down-bearing, headaches, and a tendency to general mucous membrane and skin irritation, showing itself by relaxed throat, tickling cough, *morning diarrhœa*, and urticaria or erythema. The morning diarrhœa is an almost infallible indication for it. In such a case *apis* acts like a charm in the 3rd dec. dilution.

When *Ferrum* and *Plumbum* are indicated at the time of the period, they should be continued during the interval. I have already sufficiently described the cases suited to these drugs. In fact, in prescribing homœopathically for menorrhagia in the interval, as well as at the period, we must carefully individualize each case in order to be successful, and not prescribe in a routine manner. Hence the necessity of my making a detailed paper, in order as fully as possible to point out the indications for each medicine, as each has its own separate sphere of action. And in no other disorder is it more necessary to notice what I might call the all-round symptoms in each case, over and above the specially uterine ones.

I do not, for want of space, go into the general treatment of menorrhagia—the diet, the use or non-use of alcoholic stimulants, the rest or exercise which each case may require, as these points are common to all schools of treatment. I may merely add, as I spoke of the use of the hot injection during the

period, that it ought to be used daily during the interval in the morning, while at the same time, if the patient have sufficient re-active power, a daily hip bath at 85° for ten minutes at bed-time is of the utmost benefit.

Metrorrhagia or hæmorrhage from the uterus occurring at other than the menstrual periods may depend (1) on some definite change or disease of the uterus, which will require special treatment, the hæmorrhage being only a symptom ; or (2) it may depend on causes which produce undue ovarian excitement ; or (3) as a symptom of the menopause. In the first case the treatment does not come within the scope of this paper, but if the hæmorrhage is such as to require special attention, the medicines already named, according to their indications, will be the ones required. In the second class, aconite, belladonna, and apis will be indicated. In the third case, that of the menopause, if no organic mischief is found, and the patient is not really suffering in any way from the hæmorrhage, and feels quite well, it had better be let alone, and looked on as a safety valve of nature, preventing other forms of trouble incidental to that time. But if profuse, and telling on the patient's strength, the already-named medicines will have to be resorted to, according to their indications. I need, therefore, not repeat these. When the lochial discharge after parturition continues too long, it comes under the category of metrorrhagia, and has to be treated as such with the remedies I have already mentioned, of which the chief would be china, hamamelis, crocus and sabina. But there is another medicine, for which we are indebted to Dr. Ludlam, of Chicago, and which is of marked value in such a case, viz., *Nitric Acid*. It is called for when the lochia continue so long as to produce a marked degree of debility, and loss of flesh and appetite. I might have named it among the remedies for menorrhagia, in which, given in the interval, it acts excellently, and is indicated by the state of debility which is produced. It has a very decided action here, as well as in long-lasting lochia, improving the health, strength, and appetite, as well as checking the loss. The hot water injection is in all these cases of material assistance.

### III.—ON SOME POINTS IN THE MANAGEMENT OF UTERINE HÆMORRHAGE.

BY GEORGE BURFORD, M.B.

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Hospital.*

THE chapter of therapeutics in uterine hæmorrhage is destined to considerable expansion, for this symptom can often thus be considerably relieved, even while the ultimate cause persists; while the cause itself is frequently amenable to therapeutic measures, as shown by the disappearance of the pathological antecedent to the bleeding.

That the symptom may be held in check, the ultimate cause persisting, is shown by the following case. A lady of middle age, consulted me for drenching uterine hæmorrhage. She had a very large uterine fibroid, for which operation had previously been advised by Spencer Wells—advice which she was reluctant to follow. She had lived for some years in one of the sub-tropical colonies, a residence which had not ameliorated her condition. When I saw her, the bleeding had been continuous for some time, and she was blanched and debilitated. She had latterly taken, by her own prescription, small doses of ipecacuanha, with only moderate avail. On studying the general and special symptoms, they seemed to bear a strong similarity to the provings of *secale*; the numbness of the fingers, in particular, was well marked. I prescribed *secale* 3x, and after two or three weeks' medication the hæmorrhage had entirely ceased, and has not recurred up to date—an interval of more than two years having elapsed. The fibroid still exists, having undergone no apparent diminution.

The first step in management is to search for the cause; for excessive hæmorrhage is dangerous, and uterine hæmor-

rhage may become excessive at any time. The therapeutics instituted are determined as much by the cause as by the complex of symptoms; thus uterine bleedings may be secondary to cardiac disease, or to extra-uterine gestation, or to malaria; and though the symptomatic remedy may check the bleeding, it will certainly recur if the cause is not dealt with.

Thus I saw, with Dr. Goldsbrough, a middle-aged lady who had been troubled with recurring and excessive irregular hæmorrhage for nearly five years. Various kinds of treatment had been endured by her, but with no permanent good, the bleeding always returned. Coming with this history under Dr. Goldsbrough's care, he instituted a careful search for the cause, and to this end I dilated and explored for him the somewhat bulky uterus. A polypus the size of a cherry was found and removed. The patient straightway recovered, and from that day to the present no bleeding has occurred.

Sometimes the cause is occult or inferential, particularly if the bleeding be the result of extra-uterine lesion; or, again, the symptom may persist after the primary cause has been removed; here secondary changes may be expected. But the removal of the cause is the prime element in the certainty of the cure. Often the cause cannot be removed, or is to be expressed as a constitutional rather than a local defect. The following case illustrates this point. A lady, the wife of an allopathic medical man, had been for some time the subject of considerable and persisting hæmorrhage. In accordance with pathological views, the uterine appendages were removed; no beneficial result accrued. After a time the condition grew so distressing that hysterectomy was contemplated. In this strait homœopathic advice was sought, and apis being the indicated drug, was accordingly administered. Improvement immediately followed, and ere long the previously intractable hæmorrhage had entirely ceased without further operation.

It is of the highest importance to delimit those cases where accessory measures are requisite, and those in which thera-

peutics alone can achieve success. There is a well-defined class of case, such as polypus, or hydatid mole, where continuous bleeding is at once and permanently arrested by operation. At the other extreme there is an equally well-defined type of case, *e.g.*, climacteric bleeding, hæmorrhages of virgins, and bleeding due to extra-uterine visceral lesions, where remedies have their undisputed sphere. Between these extremes lies a wide area of debateable land, which therapeutics ought to almost entirely annex. Where therapeutics fail, either the cause has been misinterpreted, or the therapeutic resources are defective. *It is an axiom in the treatment of uterine bleeding, that in every case, excepting those of the purely surgical type, therapeutics should have a prolonged and careful trial.* Only by such a plan can the therapeutic sphere be extended; only by such a scheme can we do justice to our therapeutic riches.

This axiom was accredited in the case of a lady, of some 30 years, whom I saw in consultation with Dr. B. She had for a couple of years suffered from a progressive and drenching menorrhagia, which allopathic art had been unable to assuage. Operation was finally, after a specially heavy bleeding, declared to be immediately necessary to save the patient's life. Homœopathy was now invoked, and Dr. B., after seeing the patient, asked me to meet him, with the view of clearing the ground by determining whether operation were really a matter of imminent necessity. In view of our therapeutic resources, I decided to the contrary. After one or two preliminary remedies, lycopodium was administered, and the improvement in the hæmorrhage up to the present has been most marked, the last period being practically a normal one. Although in this case not sufficient time has elapsed to stamp the cure as permanent, yet the action of the homœopathic remedy, at a crisis of severe and continuous hæmorrhage, is sufficient warrant of the potency and propriety of the therapeutic selection. So long as there exists in woman a dread of the surgeon's weapons, so long will there be a healthy stimulus to therapeutists to extend the sphere of remedies, and narrow the circle of surgery.

A comprehensive view of uterine hæmorrhage shows that the subject is far more complex in its entirety than is superficially apparent. The cause is sometimes even more important than the mere symptom ; or this particular symptom may be checked by remedies, while the cause persists, acting detrimentally in other ways. That the cause may be more harmful than the mere symptom is well illustrated in the clinical sequence here narrated. A woman in whom the menopause had been previously instituted for a few months, came to me complaining of recurring irregular hæmorrhages. Careful pelvic examination revealed nothing abnormal, and various remedies were in turn prescribed, each without avail. I then gave her a course of electrolysis which certainly arrested the bleeding so long as the application was continued ; but shortly after her return to active life the hæmorrhage returned as freely as ever. During this time repeated and careful examinations revealed no change of note in the pelvis. I watched this case carefully for two years, at the expiration of which the patient succumbed to a violent attack of influenza, but not before a neoplasm, evidently malignant, and probably sarcomatous, had filled the whole left pelvis extending up into the abdomen. The cause of hæmorrhage in this case was of more gravity than the actual symptom.

Again, the hæmorrhage may be checked by remedies, while the cause persists, acting otherwise detrimentally. I saw a lady some three years ago, who, having passed the climacteric, had been alarmed by a slight but persistent bleeding from the vagina. I found on examination a cradle pessary firmly imbedded in the vaginal walls, which must have been *in situ* for seven years. The bleeding here was, although constant, only slight, and could easily have been checked by local injections. After some trouble I literally dug out the pessary from the tissues, and the ulcerated groove in which it lay had almost penetrated into the bladder. Since the removal of the pessary, the hæmorrhage has entirely ceased.

That the appropriate remedy will, even in new growths,



ultimately remove the primary cause of the bleeding in some cases, is of the knowledge of us all. Sometimes the same remedy that is effectual in arresting the hæmorrhage will also, in the process of time, eventuate in the absorption of the new growth, where this is present. The processes of nature, and the processes of therapeutics, alike do achieve this result in a measured number of cases.

### III.—SOME CLINICAL FEATURES IN UTERINE HÆMORRHAGE.

BY WM. CASH REED, M.D.

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THE treatment of uterine hæmorrhage embraces such a huge field, and calls into requisition armamentaria of such diverse powers, that in order to write a short paper on the subject one is fain to deal with it in one of two ways, or possibly by a happy combination of both. One may give a succinct summary of one's remedies, or may relate some typical examples culled from the case book. The former is a dry and uninteresting method, and the latter frequently more interesting to the writer than the reader. I shall draw upon both sources of information in penning these original notes. In dealing with a class of cases which are met and conquered, on the one hand, by a few doses of *pulsatilla*, and on the other not until there be a total extirpation of the uterus and adnexa, one is impressed by the variety of cause, as well as the variation in symptoms, which stamp a case in its distinguishing characteristics from all others.

Speaking generally of *internal remedies*, I have learnt to place the most reliance on the following, viz., *pulsatilla*, *crocus*, *hamamelis*, *china* and *lilium tig.*, and as we are sometimes in duty bound to confess failure as well as success, it is right to record that occasionally I have found that until our old friend, the liquid extract of ergot, has been called into requisition, success has not been attained.

As to *pulsatilla*, its place is found chiefly in such cases as occur at the inception of puberty. They are marked by

irregular and too frequent menstruation, associated with anæmia, constipation, and depression of spirits. Here *pulsatilla* frequently acts conspicuously, especially if after a while small doses of *iron* be superadded. In such cases, however, over and above medication, it is the essential duty of every practitioner to insist upon physiological rest, duly proportioned to the requirements of each case. Dr. Burford has recently very ably portrayed a type of case which occurs essentially at the period of life referred to, in which the menstrual function is "halting, irregular and painful." In the "*pulsatilla* and *iron*" case the function is too frequent and too profuse. In the former type *intellectual* rest, &c., are rigorously enjoined. In the latter *physiological* rest is essential if one hope to prevent utero-ovarian troubles in after life. Unfortunately, such cases frequently occur in the humbler walks of life, amongst tailoresses and especially those who are employed working the treadle of a sewing-machine. Thanks to the present-day pressure, and the need to accomplish a maximum of work in a minimum of time, and thanks, also, to the enlightened humanity of the employers, the steam-engine accomplishes with us in the West what devolved formerly upon the employée, much to the detriment of her health. But in an upper grade of the social scale how frequently one finds that the robust mother, "who has never known a day's sickness," is impatient with the girl who does not fight against the "whims," as she thinks, of the early menstrual years. The disregard of these timely warnings results, at the *least*, in a degree of mental depression which is as an incubus in the retrospect of after-life, and at the *most*, in years of pelvic distress from only too real organic lesion. Such cases are from the life, and are before me now.

*Crocus*.—The distinctive guiding symptoms of this drug are too well known to need referring to here. Take a typical case:—Mrs. A., aged 50, consulted me about a year ago for profuse menorrhagia of the "*crocus* type," accompanied by a weight, and great tenderness in the hypogastrium. Examination revealed a large and heavy uterus, doubtless

fibroid in character. At each "period" the loss was so excessive that pallor was extreme, and excruciating headache with vertigo followed. The "flow" was like "pieces of liver." Rest in bed for two days on a hard mattress with light bed clothing, the relief of constipation, and the administration of crocus have, from time to time, had the most beneficial result, and now the patient enjoys exceedingly fair health. It is but right, however, to refer to the marvellous effect of the unsurpassed air of Dartmoor in this particular case. The low nerve force begotten of the profuse drain received a truly wonderful stimulus—abiding, too, in its effects—from the change referred to. So it is with almost all diseases characterised by this peculiarity, viz., a low tropho-neurosis, whatever be the cause of the blood deterioration, *ab initio*.

*Hamamelis*, with its derivatives and its extract, is invaluable in certain cases of uterine hæmorrhage, though it may not be easy precisely to define its peculiar sphere of action. The two latter substances applied locally—the former as a tampon with glycerine, the latter on a Playfair's probe to the endometrium—act in the most satisfactory manner.

*China* meets cases perhaps rather in their ultimate than in their immediate manifestation, when great weakness, sinking, syncope, perspiration and constipation are present. I always use the  $\phi$  tincture.

*Lilium tig.*—This remedy is one in which I have learnt to place great confidence. It meets essentially those cases in which there is a more or less constant discharge from the uterus, described as "sometimes like whites" and "sometimes like dirty water"—i.e., a muco-purulent discharge, with sometimes the admixture of blood, which may be adventitious, or which may be truly menstrual. I think the latter is frequently from the Fallopian tubes, and comes then intermittently, and is not arrested by a return to physiological health of the endometrium, when the latter has itself received effectual treatment.

Finally, a word as to *accessory measures*, which one finds

essential when the case is not met by the more usual and carefully selected drugs. I say nothing about curetting, nor yet about the removal of the uterus and adnexa. The latter, as regards therapeutic measures, is ultimate, and frequently magnificently curative in its results; the former is to be resorted to in cases of chronic metritis met with from time to time, and is also definitely curative in its results. Less severe by far than either is the local treatment of the endometrium by one or other of the following, viz., acid carbol., iodine, zinci chlor., or even of extract of hamamelis. The following case will support the admission that ergot is sometimes useful, and that minor surgical interference is sometimes essential:—

Mrs. B., aged 45, has suffered from profuse metrorrhagia for six or eight months; and her weakness is great. In spite of the careful selection of drugs by a skilled colleague the case did not improve. On examination, I found an enlarged (sound showed four inches) and subinvolted uterus, with lacerated cervix and ectropion. Extract of ergot, min. xv. *ter die* was given, with immediate and great relief, which continued, though the hæmorrhage was not *quite* cured. We decided that curetting was the right treatment, and with the object of this being done patient was admitted into hospital. It being open to doubt, however, whether the condition were now quite severe enough for that measure, I decided to try the application to the endometrium of pure carbolic acid on Playfair's probes. The result has been all that could be desired, and promises a completely successful issue. Size of uterus now three inches.

In conclusion I wish to cite a case which has been of profound interest and instruction to me, and as it is one which presents phenomena which may be varyingly interpreted by different members of our school—whose treatment will be correspondingly affected—I make no apology for giving it in detail. First let me observe that though the primary complaint of the patient, viz., uterine hæmorrhage—tends to be lost sight of in the developments of the case, yet this was the one trouble for which, in the first place, she sought my advice.

Mrs. X., age about 30, wife of an army officer, has been ill for twelve years, with what has been called "catarrh of the womb." She has been married four or five years, and has passed most of that time in India. She has one child, a fine, healthy girl of two and a-half years. Patient suffers from profuse menorrhagia, and constipation is a marked and painful symptom. There is intermittent, and at times, very profuse leucorrhœa. She has lately been under treatment by a well-known medical man in London, and has had caustics locally in abundance, and ergot internally. On Sept. 25 last I examined her and found the cervix notched on both sides—the sound showed the uterus to be three inches in length, its axis was straight, and the whole organ tended rather to the right side. There was tenderness in both ovarian regions. I diagnosed the case as subinvolution of the uterus, in part caused and maintained by the erosions spoken of, and ovarian inflammation. The *treatment* consisted of sepia, and glycerine and carbolic acid tampons. For the constipation an appropriate diet was ordered. Improvement at once ensued, and when the next "period" recurred, though the quantity was about the same as usual, the general state of the patient was obviously better in every way. I now gave *lilium tig.* 2x with marked improvement as regards the leucorrhœa. Thus matters continued on the ascending scale, until one day I was suddenly summoned by telegram, and on arrival found intense pain and tenderness in the right ovarian region, considerable pyrexia, and other signs of acute peri-oöphoritis. This was sufficiently disappointing, not to say puzzling, and I set myself at once to inquire as to the cause of the turn affairs had taken. On careful inquiry I learned that a month after the child was born in India the patient suffered from what I had no doubt from the symptoms described, was an attack of acute gonorrhœa. Here, then, was a case of gonorrhœal ovaritis, and probably also salpingitis, with, at the present juncture, implication of the adjacent peritoneum and cellular tissue.

I need not detail the history of the case for the next few

weeks ; it was one of acute suffering and some danger. The specific remedies relied upon were merc. cor. and bryonia ; *belladonna* suppositories in the rectum to ease the intense pain, and occasionally some *nepenthe* with a like object. A steady convalescence ensued. When the case was sufficiently recovered I again made an examination and found a fixed uterus and, as before, a tender right ovary. If now my conjecture, *re* gonorrhœa, were correct, of which I had no doubt, the patient was in jeopardy of a like attack which might prove fatal, and that, perhaps, in the near future. I therefore unhesitatingly advised removal of the adnexa, and was greatly relieved to find Dr. Burford, who came down to Plymouth to see the case, entirely concurred. This radical advice naturally alarmed the friends, and for corroborative purposes they sought opinion outside our school, in which I concurred.

I need not enter into particulars, except to say that the first opinion was to the effect that the symptoms were due to a fibroid, and the second—that of a well-known specialist in London—was entirely confirmatory of Dr. Burford's and my own views, except that in consequence of the marked improvement which had taken place in the patient in the interim, delay as to operation was advised, and that in the event of its performance, one set only of appendages should be removed. Thus the matter rests, and whether the advice to act with promptitude or to delay until perchance another attack occur, be the right one, I can only say with Dr. Burford, "*Dies declarabit.*"

In conclusion, it is necessary to make one or two comments. After the patient was convalescent from the acute attack described, the husband first sought my advice for gonorrhœa, which, as before shown, had, until that time, been a matter of conjecture only.

And now let us consider for a moment the question of operation. What future developments, if any, are we likely to have in this case, and what do they portend as regards the patient? A careful study of the history of such cases convinces me that, speaking broadly, *recurrent peritonitis* is

almost certain to take place sooner or later ; the *status quo* is essentially unstable. Statistics show that in patients with suppurating tubes these lead to death in about one-fourth of the cases (Cullingworth). What of the mortality after operation for the removal of the adnexa ? The same author gives this as from 5 to 10 per cent., according to the skill and experience of the operator. Then as to the advice to delay. Why wait for another attack of peritonitis, which may be fatal *per se* ? If not so, haply, it would immensely increase the difficulties of surgical interference, and correspondingly diminish the chances of recovery.

Another feature of the same advice was to remove one set only of appendages.

It has been abundantly proved that though one side start the mischief, both sides are involved in the inflammatory adhesions, and Lawson Tait has conclusively shown the fallacy of removing one set of appendages only in these cases. I have already drawn attention to the fact that this patient first came under my care for *uterine hæmorrhage*, in fact, this was her "complaint." And here I would observe that this is a very usual symptom in such cases, a point which, if lost sight of, might cause us to be led far afield.



## V.—CLINICAL CASES OF UTERINE HÆMORRHAGE.

By A. E. HAWKES, M.D.

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CASE I.—Mrs. S. E. B., age 30, was sent to me by a colleague. She gave the following history of her case on becoming an inmate of the Hahnemann Hospital.

She commenced to menstruate at 15, and for a long time the function was normal; but about three years ago, two weeks came to be the duration of the interval and the flow was excessive. She had had no children; but ten months before admission she had a miscarriage at the eighth week. The embryo came away without artificial aid, while the discharge only continued ten days. She again became pregnant and her general health improved. Miscarriage again occurred at the eighth week, after two days of great pain. The ovum seems to have escaped entire. This occurred six weeks before admission, and a sanguineous discharge has continued since. At times the flow has been greatly augmented. There has occasionally been a very little fœtor.

Secale 1x was administered, as a local examination hardly seeming to warrant active measures. The discharge notwithstanding kept on more or less for ten days, and a further examination was made. The os was found to be eroded, and the anterior lip was much tumefied. A glycerine tampon was applied, but some flow still continued and a good deal of ovarian pain was complained of. *Hamamelis* was administered every two hours. Four days after there was hardly any improvement, the discharge was dark, and pain extended down the spine into the thigh and across the back. *Platina* 6x was now prescribed. Two days afterwards the discharge was said to be diminishing, and the patient improv-

ing. The medicine was continued and a douche at 118° F. was ordered to be employed morning and evening. On December 27, patient had evidently got over another period, known by the increase of the flow. The quantity again diminished, but the patient became very nervous, although she seemed in better health. *China* 12x was substituted for the last remedy.

*January 2.*—A little discharge continuing all the time, the patient was put under the influence of chloroform, the cervix pulled down with forceps, Hegar's dilators used, and the uterine cavity carefully scraped. The uterus and vagina were packed with iodoform gauze, and a catheter was employed to empty the bladder for a short time. The pulse remained normal, and the temperature did not rise above 99° F.

The next period was natural, but a little ovarian pain necessitated the use of *hamamelis* 3x. Twelve months afterwards she reported her condition as satisfactory.

It must not be inferred that such measures, simple though they are, are often required for metrorrhagia after miscarriage, but if such drugs as china and crocus, sabina and hamamelis do not speedily act the expedient should be thought of.

Having regard to my own experience, I would urge the removal of portions of placenta, adhering after abortion, even if foetus and profuse hæmorrhage are absent. I do not think instruments are often needed, but if the practitioner can introduce his hand, with the aid of chloroform if necessary, into the vagina, hooking down the uterus with the index finger, and then pressing it down with the disengaged hand he will be able to detach everything that ought to come away, and thus avoid the unpleasant reflection that he has left something behind which may cause much anxiety in the future.

CASE II.—M. E., age 16 years, admitted into the Hahnemann Hospital, February 22, 1893.

She stated that she was quite well about ten days before, when she took cold and began to cough.

Soon after, well-marked purpura maculæ appeared, and on admission they were found to extend all over the body, but none appeared on the face save on the forehead and chin.

About a fortnight before there had been profuse metrorrhagia. This had subsided for two or three days, but had recommenced on day of admission.

On that day, *hamamelis* 1 was ordered, but after two days *phosphorus* 6 was substituted.

No good having resulted after several days' trial, *secale*  $\phi$  gt. ii.—v. was ordered; and under the influence of that drug the purpura and metrorrhagia speedily disappeared.

The catamenia appeared again on March 21, but were in no degree excessive.

CASE III.—A form of uterine hæmorrhage apparently uninfluenced by drugs is produced by the well-known mucous polypus. S. M., age 42, was admitted into the Hahnemann Hospital suffering from metrorrhagia of long duration. On examination, a small polypus was discovered, protruding from the os. This was removed with a small snare. Scissors would have been better, and have been used in later cases.

The metrorrhagia recurred after a time, and the patient was re-admitted sixteen months afterwards.

On this occasion the pedicle of the polypus was thoroughly twisted, and this expedient was quite successful.

Perhaps the most troublesome forms of uterine hæmorrhage are those associated with the presence of uterine fibroids, but the well-known indications for such drugs as *sabina*, *crocus*, and *millefolium*—perhaps *arsenicum* should be added—will often render further measures unnecessary.

I wish further to refer to that form of metrorrhagia which occurs in connection with inflammatory deposits occurring after parturition.

No one accustomed to frequent digital examinations can have failed to note how often on discovering a split in the cervix, if the finger be carried further into the fornix, nearly always the left, a mass of inflammatory deposit is reached, or it may be only cicatricial tissue remains.

I have again and again been told that the only help for these cases is to be obtained by operation ; but I have at least four cases in my mind as I write, where other means succeeded, and in three cases out of the four pregnancy occurred, and parturition was successfully accomplished.

Not unfrequently in these cases a fragment of membrane has been retained, some fever has occurred, a cellutic deposit has resulted and a very tedious convalescence has ensued.

After the patient has got up the lochia is long in ceasing. It often assumes a more sanguineous character, and long after, clots form and come away. After a short absence the flow returns, the patient loses flesh, and the friends fear some untoward result, and begin to question the skill of the medical attendant.

In such cases rest in bed, the hot douche, and *crocus*, *sabina*, *china*, and perhaps *millefolium*, help to check the hæmorrhage. *Secale* is not so frequently indicated in my experience.

After the hæmorrhage has been controlled, and perhaps after a surgeon has been called in, who, in a friendly way, has confidently urged an operation to get rid of the lump, if *aurum muriat. natronat.* be administered for some time, the mass will be reduced to a minimum, and the patient restored to her wonted health.

CATALOGUED  
NOV 23 1897  
E. H. B.

THE LONDON  
HOMŒOPATHIC  
HOSPITAL REPORTS.



BYRES MOIR, M.D.

VOL. III.

LONDON  
LONDON HOMŒOPATHIC HOSPITAL.

December, 1893.

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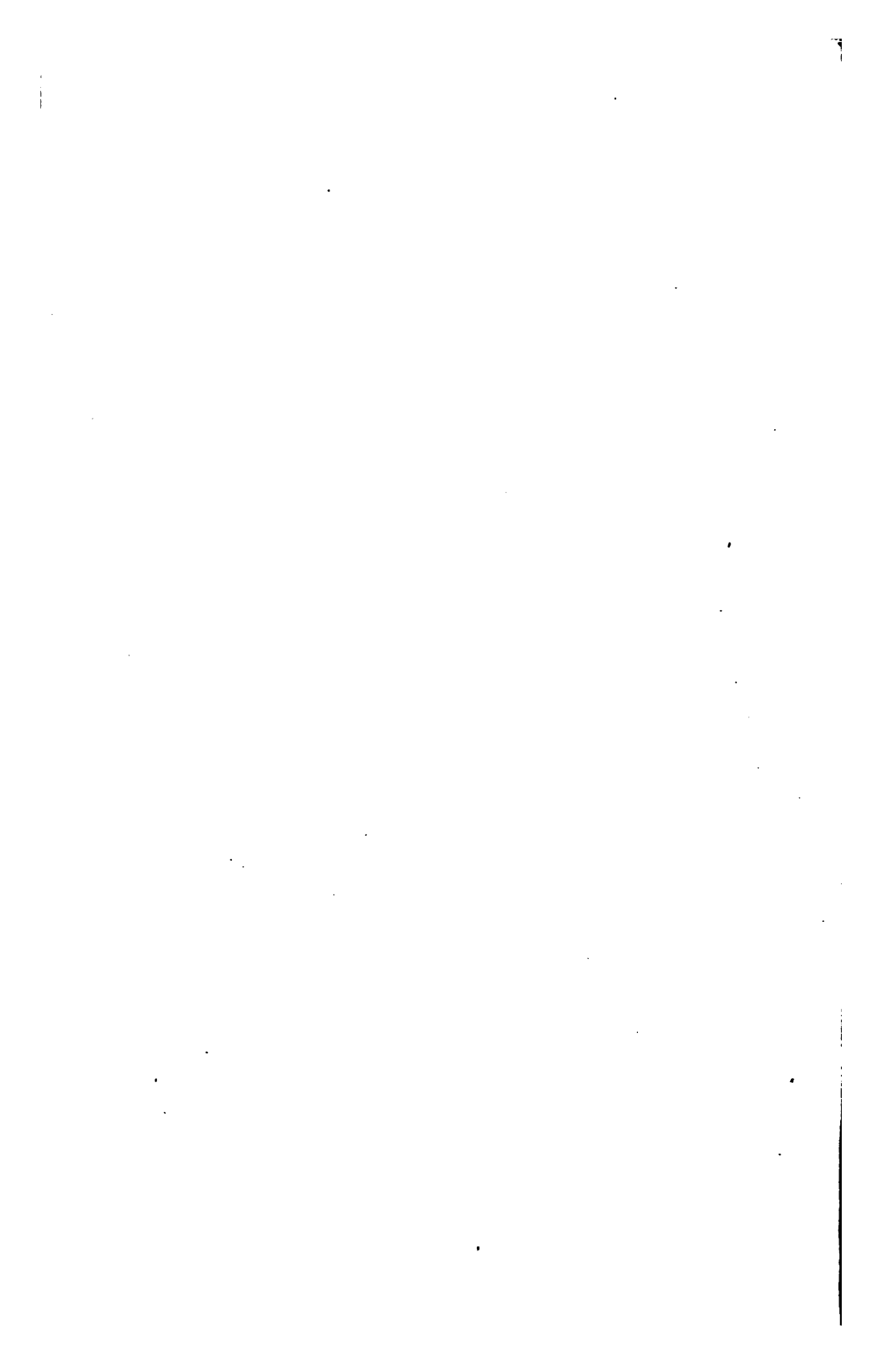
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warmth extending from lips, which quickly became dry, to deep into cesophagus. Drawing in air caused agreeable coolness. ~~Slight shivering over lower, then over upper extremities, with goose skin in those parts, which became more general and stronger as the cold extended. The shivering is felt especially between skin and muscles, increases in intensity, so that rigor comes on, whenever he keeps quiet.~~ On moving briskly, walking quickly in open air, all the symptoms decline, but return immediately with double strength when standing or lying; at same time extraordinary prostration, indifference, distaste to all sorts of work, crossness, and sensitive irritability. ~~Appetite gone, eating does not relieve the troublesome eructation of hot air with taste of alcohol, but soup or meat causes loathing.~~ In afternoon these symptoms attained their height; ~~the rigor was so severe that he must lie down, for coldness comes on, he is chilly under two blankets.~~ At same time throbbing in temporal arteries, and feeling as if hair stood on end. These spots were sensitive to touch. Slight burning in eyes, twitching and vision of sparks; occasionally roaring in ears, with sensitiveness to any noise. Breath hot, respiration quick, at each deep breath oppression, anxiety and painful stitches betwixt scapulæ, on one side or other of chest, mostly r., but most severe from scapulæ to spine; pulse strong, full, slightly quickened (85, usually 70). With increase of cold very frequent yawning and stretching of limbs every minute, during latter symptom the limbs, during former the breathing seemed too short. ~~Towards 5 p.m. coldness gives place to warmth, occasionally interrupted by slight shivering. During increase of heat, which ended with slight sweat,~~ the sexual desire was much increased. He could only get rid of erections by getting out of bed. All symptoms declined about 7 p.m., except violent shooting in glans penis when urinating, with emission of hot dark urine; this only disappeared on 3rd d. (*Ibid.*)

15. Dr. J. STERZ, æt. 27, sanguine temperament. a. 1st February, 10 a.m., 3 drops of tinct. ~~Afternoon, contused pain in r. testicle;~~ e., weakness of knees; n., many dreams. 3rd.—5 drops; same symptoms of knees and sleep. 4th.—7 drops; same symptoms; after midnight, burning about navel, lasting 1 h.; abdomen tense and distended; great discharge of flatus. 5th.—10 drops; eruption of red pimples on flexor side of thumb, index and middle finger, painful when pressed; e., weakness of knees; n., many dreams, oppression of chest, compelling frequent inspirations. 6th.—15 drops; afternoon, abdomen distended with flatulence and tense; great discharge of flatus; e., weakness of knees, with frequent stitches in l. knee, frequent yawning, scraping in throat, feeling as if something were sticking in fauces, causing frequent swallowing; ~~confusion in forehead;~~ jerking pain in nape, with feeling of stiffness; aching pain in sacrum; ~~very perceptible heart's beats when sitting still and lying;~~ n., many dreams, with oppression of chest and frequent deep inspiration. 7th.—20 drops; after 1 h. redness and heat of face, lasting  $\frac{1}{2}$  h.; coryza with flow of thin mucus; feeling as if larynx were compressed from both sides. The e. weakness of knees extends over r. thigh and leg; ~~contused pain in r. testicle;~~ tightness and pressive feeling in chest, especially in



HIC  
991

